UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

UNITED STATES OF AMERICA,

Plaintiff,

v. Case No. 05-11576-DPW

PARTNERS HEALTHCARE SYSTEM, INC.,

Defendant.
_____/

DECLARATION OF MARK H. CHURCHILL IN SUPPORT OF DEFENDANT PARTNERS HEALTHCARE SYSTEM, INC.'S SUR-REPLY IN FURTHER OPPOSITION TO PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

I, Mark H. Churchill, declare:

1. I am a member of the District of Columbia Bar and a partner in the law firm of McDermott Will & Emery LLP, attorneys for defendant Partners Healthcare System, Inc. ("Partners"). I am admitted *pro hac vice* in this case. I have prepared this declaration to authenticate the documents annexed as exhibits. I am personally familiar with these documents, based on my representation of Partners in this adversary proceeding with plaintiff United States of America. I have personal knowledge of the facts set forth in this Declaration and, if called as a witness, I can and will testify to these facts in a court of law. I make this declaration in support of Partners Healthcare System, Inc.'s Sur-Reply in Further Opposition to Plaintiff's Motion for Summary Judgment, filed this same date.

2. Attached as Exhibit 1 hereto is a true and correct copy of Defendant Partners Healthcare System, Inc.'s Amended Objections and Responses to Plaintiff's First Set of Interrogatories.

3. Attached as Exhibit 2 hereto is a true and correct copy of Partners' 2001

enrollment guide, "Benefits for Residents," produced by Partners in this litigation as PHS 000004-000032.

4. Attached as Exhibit 3 hereto is a true and correct copy of Partners' 2002 enrollment guide, "Benefits for Residents," produced by Partners in this litigation as PHS 000033-000067.

5. Attached as Exhibit 4 hereto is a true and correct copy of Partners' 2003 enrollment guide, "Benefits for Residents," produced by Partners in this litigation as PHS 000068-000102.

6. Attached as Exhibit 5 hereto is a true and correct copy of Partners' 2003 enrollment guide for Massachusetts General Hospital and Massachusetts General Physicians Organization, "Professional Staff Benefits Program," produced by Partners in this litigation as PHS 003226-003255.

7. Attached as Exhibit 6 hereto is a true and correct copy of Partners' 2001 enrollment guide for Brigham and Women's/Faulkner Hospitals and Brigham and Women's Physicians Organization, "Benefits for Professional Staff," produced by Partners in this litigation as PHS 003264-003292.

8. Attached as Exhibit 7 hereto is a true and correct copy of the "Family and Medical Leave Policy" for Brigham and Women's Hospital Medical Staff, produced by Partners in this litigation as PHS 003303-003307.

I declare under the penalty of perjury that the foregoing is true and correct. Executed on

this 12th day of April, 2006.

/s/ Mark H. Churchill
Mark H. Churchill

CERTIFICATE OF SERVICE

I hereby certify that this document filed through the ECF system will be sent electronically to the registered participants as identified on the Notice of Electronic Filing and paper copies will be sent to those indicated as non registered participants on April 12, 2006.

/s/ Mark H. Churchill
Mark H. Churchill

WDC99 1221060-1.057158.0039

EX. 1

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

UNITED STATES OF AMERICA,

Plaintiff,

v. Case No. 05-11576-DPW

PARTNERS HEALTHCARE SYSTEM, INC.,

Defendant.
_____/

DEFENDANT PARTNERS HEALTHCARE SYSTEM, INC.'S AMENDED OBJECTIONS AND RESPONSES TO PLAINTIFF'S FIRST SET OF INTERROGATORIES

Defendant Partners Healthcare System, Inc. ("Partners"), by and through its undersigned counsel, and pursuant to Rules 26 and 33 of the Federal Rules of Civil Procedure, hereby submits amended responses and objections to Plaintiff United States of America's First Set of Interrogatories.

GENERAL OBJECTIONS

1. Partners incorporates these General Objections into each and every one of its responses to Plaintiff's interrogatories.

2. Partners objects to each and every interrogatory to the extent that it is unreasonably vague, overly broad, ambiguous, repetitious, unduly burdensome, or purports to require the disclosure of information beyond the scope of permissible discovery under the Federal Rules of Civil Procedure or this Court's Local Rules.

3. Partners objects to each and every interrogatory to the extent that it seeks information or documents protected by the attorney-client privilege, the attorney work product

doctrine, or other applicable privileges. The inadvertent production of any privileged information shall not signify any intent by Partners to waive any applicable privileges.

4. Partners objects to each and every interrogatory to the extent that it is not reasonably calculated to lead to the discovery of admissible information.

5. Partners objects to each and every interrogatory using "refer," relate," or "respecting," or similar terms to the extent that they are used in a manner that would render such requests overly broad, vague, or ambiguous, or require subjective judgment and speculation on the part of Partners.

6. Partners objects to each and every interrogatory to the extent that it seeks identification, descriptions, and/or production of "all" documents "all" agreements, etc., as being overly broad and unduly burdensome.

7. Partners objects to each and every interrogatory to the extent that it calls for the production of documents or information already in the possession of the Plaintiff or publicly available to any party, on the grounds that such a request is unduly burdensome.

8. Where Partners states below that "responsive documents will be produced," this does not constitute a representation that any such documents exist, can be identified and located and are non-privileged; rather that they will be produced if they exist and can reasonably be identified and located and are non-privileged.

9. Partners' responses are based on its current understanding of the issues involved in this litigation and the facts pertaining to those issues. Partners reserves the right to amend or supplement its responses based on its continuing investigation of this case.

SPECIFIC OBJECTIONS AND RESPONSES

Interrogatory No. 1: Does the defendant contend that the amounts paid to the residents in question during the period in issue are not subject to the FICA tax because they are exempt from such tax under Internal Revenue Code § 3121(a)(20)? If so, state each fact, and identify each document, the defendant relies on to support that contention.

Partners' Response: Partners incorporates by reference all General Objections. Partners further objects to this request on grounds that it is overly broad and unduly burdensome, particularly insofar as it asks for each fact and each document relied upon by Partners. Subject to and without waiving these objections, Partners responds as follows:

Partners contends that the amounts paid to the residents in question during the period in issue were not subject to the FICA tax because the payments were not wages under Section 3121(a). Such payments were not made for services rendered to Partners and were not otherwise remuneration for employment. Instead, the payments were made to residents in their role as trainees in Partners' Graduate Medical Education ("GME") program to help pay for their living expenses while trainees in the program. As with scholarships under Section 117(c), these stipends do not represent an amount received for any services rendered. Partners' payments to the residents were not paid as a *quid pro quo*. The GME training provided increased competency, ability, and experience to residents in various specialized areas of medicine and the stipends were paid to allow the residents to devote their full time and attention to their graduate education training.

Further, Medicare, not Partners, was the primary payer of the funding for the residency program and such funding was based upon the number of residents enrolled in Partners' training program, rather than upon any services provided. The training residents received through

Partners' residency program was pursuant to strict GME guidelines and accredited by the Accreditation Council for Graduate Medical Education ("ACGME"). During the ACGME residency training program at Partners, patients were seen by residents and attending staff physicians, but Partners only charged for services performed by the attending staff physicians. Residents were continually supervised by attending staff physicians (nearly all of whom held faculty appointments at Harvard Medical School) resulting in duplication, not substitution, of patient care services, so that any benefit received by Partners was incidental to the primary purpose of providing an education to the residents. The stipends to residents were not conditioned upon performance or the number of patients seen. Medicare had no expectation of a return benefit for funding Partners' residency program, and there was no expectation, nor requirement, that the residents would remain at Partners following the completion of their residency programs.

At this time, Partners has not come to a conclusion as to whether it also contends that its residents were not subject to the FICA tax under Section 3121(a)(20).

The documents that Partners relies upon in support of its position include, but are not limited to, Revenue Ruling 60-378, IRS Notice 87-31, and an IRS letter ruling to Partners granting a FICA exemption for fellowship stipends paid to support Partners' research fellows during training.

Interrogatory No. 2: If you are unable to unconditionally admit any of the UNITED STATES' FIRST REQUESTS FOR ADMISSIONS TO THE DEFENDANT numbered 1-21, then for each such request that you are unable to unconditionally admit, state the following:

a. The request number;

b. Every reason why you are unable to unconditionally admit such request;

c. All facts you rely on to support your denial of each such request;

d. The identity of all documents you rely on to support your denial of each such request; and:

e. The names of all persons who have knowledge of the reasons and facts set forth in 2(b, c) above.

Partners' Response: Partners incorporates by reference all General Objections.

Partners further objects to this request on grounds that it is overly broad and unduly burdensome.

Subject to and without waiving theses objections, Partners states the following:

Request for Admission No. 7: Partners is unable to admit that "[t]he residents in issue are not 'candidates for a degree' within the meaning of Internal Revenue Code § 117(a)" because this requests improperly calls for a legal conclusion.

Request for Admission No. 10: Partners is unable to admit that "[t]he stipends paid to the residents in issue were based upon nationally established rates by postgraduate year, with a locality adjustment" because the stipends it paid were not calculated in such manner. *See* Interrogatory No. 4. Persons with knowledge of these facts are Karen McCormack and Janice Rogers.

Request for Admission No. 12: Partners is unable to admit that "[t]he hospital to which each resident in issue was assigned paid all stipends to such residents" because all stipends were paid by Partners. Persons with knowledge of these facts are Janice Rogers, Ramzi Hanania, Mark Grubbs, Debra Weinstein, M.D., and Georgi Bland.

Interrogatory No. 3: Describe in detail the organizational structure of the defendant, including its relationship to all hospitals and other institutions within its organization and identify any charts or other graphic depictions of these organizations.

Partners' Response: Subject to and without waiving the General Objections, Partners will provide documents pursuant to Federal Rule of Civil Procedure 33(d) in response to this interrogatory, at Bates Nos. PHS 000175-000184.

Interrogatory No. 4: Describe in detail the methodology used to compute the amounts paid to the residents for each of the years during the period in issue. State also what entity within the defendant's organization made these payments to the residents during the period in issue.

Partners' Response: Partners incorporates by reference all General Objections. Partners further objects to this request on grounds that it is overly broad and unduly burdensome. Subject to and without waiving these objections, Partners states as follows:

In computing the amount of resident stipends, Partners begins by reviewing market data from the most recent *AAMC Survey of Housestaff Stipends, Benefits and Funding*, which has been published annually by the Association of American Medical Colleges ("AAMC") since 1968. Both medical schools and teaching hospitals submit survey data to AAMC. Partners selects the 75th percentile for the Northeast region as a target point for establishing the next year's stipends.

Data is collected from Human Resources on the stipends paid to the current resident population and is used to calculate the percentage of residents associated with each institution as a basis for the next academic year's costing. Next, a current status analysis is put together by breaking down the current population by Post Graduate Year (PGY) level to attain the number of residents in each PGY level. The current Partners academic year stipend for each level is entered onto the spreadsheet. Current payroll costs are calculated by entity based on the current Partners stipend multiplied by the current number of Partners residents in each PGY. Using the data reported in the AAMC Survey, Partners calculates the variance between the 75th percentile for the Northeast region and the current PHS stipends for each level.

From this point, a budget neutral costing model using the current fiscal year salary budget increase is prepared as well as other iterations based on current departmental concerns or larger than expected variances between the AAMC data and the Partners stipend levels. The final,

most appropriate model would then be used by the Vice President for Graduate Medical Education to present to the various committees during the approval process, including but not limited to the Partners Education Committee as well as Senior leadership from Partner's Corporate, Massachusetts General Hospital and Brigham and Women's Hospital.

All of Partners' residents except for those at Faulkner Hospital, North Shore Medical Center, Newton-Wellesley Hospital, and one program at McLean Hospital were paid by Partners.

In addition to the foregoing answer, Partners will provide documents pursuant to Federal Rule of Civil Procedure 33(d) in response to this interrogatory, at Bates Nos. PHS 000400-000405.

Interrogatory No. 5: State whether the residents were eligible for any benefits, such as leave (sick, vacation, etc.), health and dental insurance, short and long-term disability, life insurance, participation in a retirement plan, employee assistance programs, costs of cleaning uniforms, parking and meal subsidies. If so, describe in detail each such benefit, stating which entity (for example, Massachusetts General Hospital or Brigham and Women's Hospital) provided each benefit and what cost, if any, was charged the resident for each such benefit. State also whether these benefits were made available to other employees at the defendant, and if so, whether those other employees were charged a fee to obtain such benefits.

Partners' Response: Partners incorporates by reference all General Objections. Partners further objects to this request on grounds that it is overly broad and unduly burdensome. Subject to and without waiving these objections, Partners will also provide documents pursuant to Federal Rule of Civil Procedure 33(d) in response to this interrogatory, at Bates Nos. PHS 000001-000174.

Interrogatory No. 6: Prior to filing the claims for refund in this case, state how long you, or any predecessor organization, had treated residents' payments as wages from employment subject to the FICA tax. Also state every reason why you changed the tax treatment of

these payments and identify all documents that reflect the reasons for making the change in the FICA tax treatment of the residents.

Partners' Response: Partners incorporates by reference all General Objections. Partners further objects to this request on grounds that it is not likely to lead to the discovery of relevant evidence and seeks information or documents protected by the attorney-client privilege, the attorney work product doctrine, or other applicable privileges.

Interrogatory No. 7: Describe in detail the process by which each resident was selected for participation in a residency program during the period in issue. Identify each document that was considered in determining whether or not to accept a prospective resident's application.

Partners' Response: Partners incorporates by reference all General Objections. Partners further objects to this request on grounds that it is overly broad, vague, ambiguous, and unduly burdensome. Subject to and without waiving these objections, Partners states that although each residency program may tailor its resident selection process to fit its own needs, most programs generally use the following criteria and approach as required by ACGME Institutional Requirements Section III.A.:

All applicants must be graduates or pending graduates of:

- A LCME (Liason Committee on Medical Education) accredited medical school;
- An AOA (American Osteopathic Association) accredited medical school;
- A medical school listed in the World Health Organization Directory of Medical Schools; or have
- Completed a Fifth Pathway program provided by an LCME-accredited medical school.

Applicants who are still in medical school may submit applications through the Electronic Residency Application Service ("ERAS") or through other means as required by each department. ERAS is a service that transmits residency, fellowship and osteopathic internship

applications, letters of recommendations, Dean's Letters, medical school transcripts, COMLEX transcripts, a minimum of two letters of references from physicians familiar with the applicant's performance, and other supporting credentials from applicants and their designated Dean's Office to program directors using the Internet. Applicants who have completed medical school may generally submit their materials directly to the department of interest.

In many departments, recruitment committees under the supervision of the program director, then evaluate and select the applicants they believe to be the most qualified for the positions within the training program. In selecting from among qualified applicants, programs typically participate in an organized matching program, such as the National Resident Matching Program, when a matching program is available.

Selected candidates are invited to interview. Candidates are evaluated based on the following criteria:

- Ability
- Aptitude
- Academic credentials
- Communication skills
- Personal qualities, such as motivation and integrity

Interviewees are provided with, or directed to, benefits information, graduate trainee policies, and department specific information. Upon selection, individual contracts are prepared by the department for signature by the selected candidates. Subsequent appointment is contingent upon successful completion of the PGY-1 year.

Interrogatory No. 8: Identify any and all persons who assisted in the preparation of the responses to these interrogatories as well as the requests for admission and the requests for production of documents served upon the defendant contemporaneously herewith, identifying which response(s) each such person assisted in preparing.

Partners' Response: Partners incorporates by reference all General Objections. Partners further objects to this request on grounds that it is overly broad, vague, ambiguous, and unduly burdensome. Subject to and without waiving these objections, Partners states that the following people assisted in the preparation of the discovery requests:

Interrogatories

Response to Interrogatory No. 1: Debra Weinstein, M.D. and Ramzi Hanania
Response to Interrogatory No. 2: Karen McCormack, Janice Rogers, Ramzi Hanania, Mark Grubbs, Debra Weinstein, M.D., and Georgi Bland
Response to Interrogatory No. 3: Joan Elias, Esq. and Naomi Bass, Esq.
Response to Interrogatory No. 4: Karen McCormack and Janice Rogers
Response to Interrogatory No. 5: Mark Grubbs
Response to Interrogatory No. 6: N/A
Response to Interrogatory No. 7: Debra Weinstein, M.D. and Georgi Bland
Response to Interrogatory No. 8: Joan Elias, Esq., Naomi Bass, Esq., and Ramzi Hanania

Requests for Admission

Response to Request Nos. 1-9: Debra Weinstein, M.D. and Georgi Bland
Response to Request No. 10: Karen McCormack and Janice Rogers
Response to Request No. 11: Debra Weinstein, M.D. and Georgi Bland
Response to Request No. 12: Janice Rogers, Ramzi Hanania, Mark Grubbs, Debra Weinstein, M.D., and Georgi Bland
Response to Request No. 13: Debra Weinstein, M.D. and Georgi Bland
Response to Request No. 14: Mark Grubbs
Response to Request No. 15: Debra Weinstein, M.D. and Georgi Bland
Response to Request No. 16: Debra Weinstein, M.D. and Georgi Bland
Response to Request No. 17: Debra Weinstein, M.D. and Georgi Bland
Response to Request No. 18: Mark Grubbs
Response to Request No. 19: Ramzi Hanania
Response to Request No. 20: Ramzi Hanania
Response to Request No. 21: Joan Elias, Esq. and Naomi Bass, Esq.

Responses to Requests for Production of Documents

Response to Request No. 1: *See* persons who assisted in preparing interrogatory responses
Response to Request No. 2: N/A
Response to Request No. 3: Naomi Bass, Esq.
Response to Request No. 4: Naomi Bass, Esq.

Response to Request No. 5: Debra Weinstein, M.D. and Georgi Bland
Response to Request No. 6: Debra Weinstein, M.D. and Georgi Bland
Response to Request No. 7: Debra Weinstein, M.D. and Georgi Bland
Response to Request No. 8: N/A
Response to Request No. 9: Debra Weinstein, M.D. and Georgi Bland
Response to Request No. 10: Debra Weinstein, M.D. and Georgi Bland
Response to Request No. 11: Joan Elias, Esq., Naomi Bass, Esq., and Ramzi Hanania
Response to Request No. 12: Debra Weinstein, M.D. and Georgi Bland
Response to Request No. 13: N/A
Response to Request No. 14: Debra Weinstein, M.D. and Georgi Bland
Response to Request No. 15: Debra Weinstein, M.D. and Georgi Bland
Response to Request No. 16: Susan Gormley
Response to Request No. 17: Linda Weinstein and Carol Johnston
Response to Request No. 18: Karen McCormack and Janice Rogers
Response to Request No. 19: Joan Elias, Esq.

Dated: January 18, 2006

Christopher Kliefoth /sh

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Attorneys for Partners Healthcare System, Inc.

WDC99 1183634-1.057158.0039

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing DEFENDANT PARTNERS HEALTHCARE SYSTEM, INC.'S AMENDED OBJECTIONS AND RESPONSES TO PLAINTIFF'S FIRST SET OF INTERROGATORIES was served on this 18th day of January, 2006 by email on:

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U.S. Department of Justice
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Washington, DC 20044
stephen.t.lyons@usdoj.gov
(202) 307-6546

Sarah E. Hancur

Sarah E. Hancur

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VERIFICATION

I, Peter K. Markell, verify that I am currently Vice President of Partners Healthcare System, Inc. ("Partners"); that to the best of my present knowledge and information, the facts stated in Partners' Amended Objections and Responses to the United States of America's First Set of Interrogatories are true and accurate; and that I am authorized to make this verification.

I declare, under penalty of perjury, that the foregoing is true and accurate.

Date: January 20, 2006

Peter K. Markell

EX. 2

PARTNERS™

BENEFITS FOR RESIDENTS



2001

PARTNERS HEALTHCARE SYSTEM

PHS 000004

FOR YOUR PERSONAL BENEFIT

Partners HealthCare System is pleased to offer you

PARTNERS™

BENEFITS FOR RESIDENTS

Partners Benefits for Residents will offer you the flexibility you need to design a benefits program that best suits your needs.

Prior to enrolling, we encourage you to:

- make use of this informational guide by reading through each of the benefit descriptions, or
- contact your dedicated service representative at (617) 726-8133 (then press 5 or 6) if you need help with enrollment.

The Benefits Office assigns two full-time service representatives to assist our residents and fellows. Your service representatives can be reached by calling 726-8133, then pressing 5 or 6, and both are available at the hospital campuses on a regular basis. At BWH, your service representative is available onsite at the Galleria in the Human Resources Office. Our MGH service representative is available at the Professional Staff Benefits Office.

TABLE OF CONTENTS

HIGHLIGHTS

Partners Benefits for Residents is designed for your personal benefit. With Partners Benefits for Residents, you can select the benefits that will best meet your needs and the needs of your family.

- You will be provided with Choice Pay you can use to purchase the benefits of your choice from the options available.
- You can choose from six medical plans to protect yourself and your family in the event of illness or injury. A prescription drug benefit managed by Merck-Medco offers you low co-payments and the convenience of a mail service program.
- Two dental plans offer you the level of coverage that is right for your situation.
- A vision care plan offers a cost-effective way for you to get checkups and corrective lenses.
- You can purchase different levels of coverage for medical, dental and vision care (including coverage for your qualifying same-sex domestic partner), tailoring each to best fit your special needs.
- Two Tax Saver Accounts save you tax dollars and reduce your out-of-pocket costs for health care and dependent day care.
- Long-term disability insurance, with unique features for residents, is available for financial protection in the event you cannot work due to an extended illness or injury.
- Basic group life insurance (paid by Partners) in an amount equal to your annual salary will provide protection for your survivors.
- Optional group life insurance allows you to purchase additional life insurance for yourself, your spouse or your dependents.
- Accidental death and dismemberment insurance is available to protect you and your spouse or same-sex domestic partner.

You must make your elections within 30 days of your benefits eligibility date in accordance with IRS regulations that govern the plans. **Coverage is effective on the date you become eligible.**

Information contained in this guide is a summary of the Partners Benefits for Residents Program. If there is a discrepancy between this summary and the plan documents, the plan documents will govern. Plan documents are available in the Benefits Office.

DECISIONS
ABOUT BENEFIT SELECTIONS

To use Partners Benefits for Residents to your advantage it is necessary to understand the choices you will be making. Take a careful look at this guide, review your Personal Benefits Summary, or your rate sheet, if you are newly eligible for benefits. Use the worksheet on page 31 of this booklet – and keep the following questions in mind.

- Which medical plan is best for my family and me? Could I be covered under another medical plan and use all available Choice Pay to purchase other benefits?
- Should I buy dental coverage for myself and my family? What level of dental coverage should I choose?
- Should I buy vision care for myself and my family?
- Should I buy long-term disability coverage?
- Will I need more life insurance than one times my annual base salary?
- Do I need to buy optional life insurance for my dependents?
- Should I participate in either or both Tax Saver Accounts to pay for certain health care and dependent care expenses?
- Should I begin saving for retirement?

If you are eligible for coverage under another medical plan, you should review that coverage to avoid signing up for a benefit that you may not need. Should that be the case, you could use your Choice Pay toward the purchase of other benefits.

ELIGIBILITY

You are eligible for Partners Benefits for Residents if you are a resident and you:

- Have an appointment at a sponsoring institution, and
- Are a monthly-paid regular (status 1) resident scheduled to work at least 87 hours per month at a standard hospital salary of at least $833.33 per month.

Coverage is effective on the date you become eligible.

DEPENDENT ELIGIBILITY

Your eligible dependents are your legal spouse or same-sex domestic partner and your dependent unmarried children under age 19. Unmarried children under age 25 who are full-time students are also eligible. For coverage to continue during vacation periods, the child(ren) must be scheduled to enter school the next semester. Your medical and dental plans will request proof of student status at least annually.

Unmarried dependent children of your same-sex domestic partner are also eligible for medical coverage, as long as they otherwise qualify as dependents.

COVERAGE FOR YOUR SAME-SEX DOMESTIC PARTNER

Your same-sex domestic partner may enroll for coverage on the same basis as a spouse. Throughout this guide, any reference to spousal eligibility should also be assumed to include your same-sex domestic partner, unless stated otherwise. Contact the Benefits Office for an informational packet if you are interested in coverage for your same-sex domestic partner and/or the dependent children of your same-sex domestic partner.

To be eligible for same-sex domestic partner coverage, you and your partner must be at least 18 years of age and:

- Not be married to anyone else or be the domestic partner of anyone else;
- Not be related by blood closer than would bar marriage under the law;
- Be jointly responsible for living expenses in a permanent residence that you share;
- Expect your relationship to be permanent; and
- Agree to notify the appropriate parties of any change in the circumstances of your relationship.

Dependent children of qualified same-sex domestic partners are also eligible for coverage on the same basis as step-children. Federal law prohibits you, however, from using either your Dependent Care Account or your Health Care Account to reimburse yourself for expenses incurred by your same-sex domestic partner or his/her children.

CHANGES
AFTER THE ENROLLMENT DEADLINE

Open enrollment in Partners Benefits for Residents is held annually, usually in late fall. All choices become effective on the first date of the plan year – each January 1. **Newly eligible employees have 30 days to enroll in the Partners Benefits for Residents program.**

After the enrollment deadline has passed, under IRS regulations you may not add, change or cancel your pre-tax benefit elections until the next plan year, unless you have a qualified change of status.

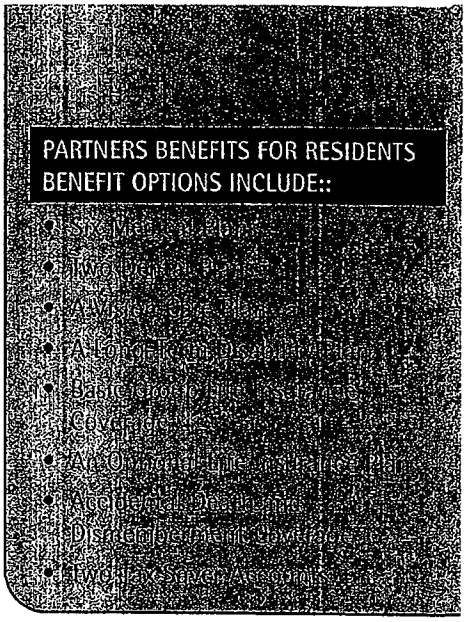
A qualified change of status occurs if you experience one of the following:

- Marriage or divorce
- Addition of a dependent through birth, adoption or change in custody
- Death of spouse or dependent
- Gain or loss of eligibility for Medicaid, Medicare or other group insurance
- You or your spouse change from benefits-eligible to benefits-ineligible status, or vice versa
- Your spouse's employment ends
- You move out of your HMO's service area
- Gain or loss of full-time student status for dependent age 19 to age 25

The change in coverage you request must be consistent with the change of status that you experience and must be requested within 30 days of the change of status.

Changes to your life insurance elections are allowed after open enrollment. However, adding or increasing life insurance coverage is subject to evidence of good health. Changes or new elections for LTD are allowed at open enrollment and are also subject to evidence of good health.

PART 1:
PARTNERS BENEFITS FOR RESIDENTS



Partners Benefits for Residents is a program that gives you a choice about how Partners dollars are spent on your behalf.

Partners Benefits for Residents is designed to reflect your personal choice by allowing you to select the options that best suit your needs and the needs of your family. Each year during the annual open enrollment period you get an opportunity to reassess your needs and elect your benefits for the following plan year, which begins on January 1.

CHOICE PAY

Each year Partners gives you Choice Pay, which you can use to purchase benefits that meet your personal needs.

There are three types of Choice Pay available under Partners Benefits for Residents.

Basic Choice Pay

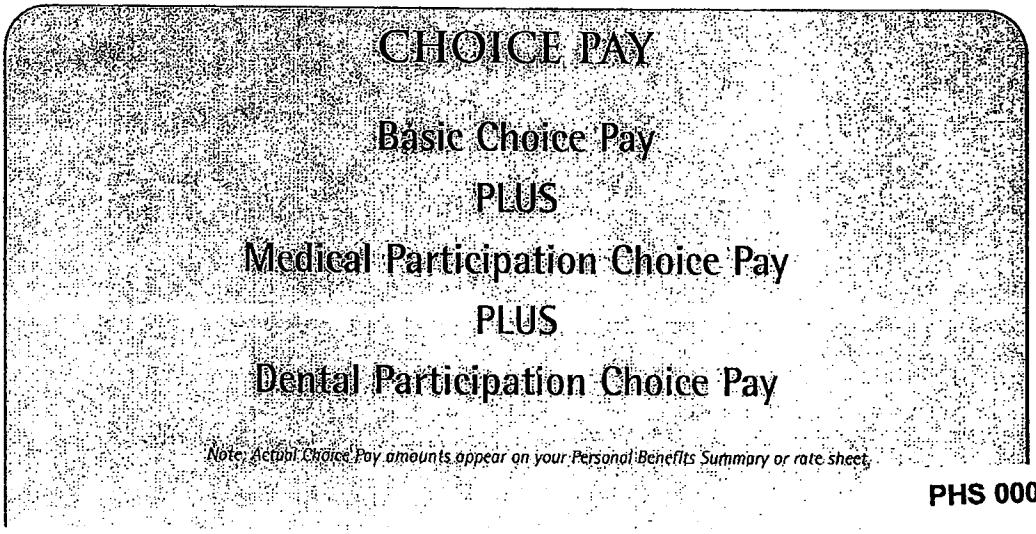
You will receive a basic amount which can be used to purchase benefits.

PLUS

Medical and/or Dental Participation Choice Pay

If you enroll in one of the medical or dental plans, you will receive an additional amount based on the level of coverage you select:

- Employee
- Employee and Children
- Employee and Spouse
- Family



IF YOU HAVE EXTRA CHOICE PAY

If you have extra Choice Pay that you do not wish to use for benefits, it can be taken in cash as additional taxable pay (provided you are covered under a medical plan).

IF YOU CHOOSE MORE BENEFITS THAN YOU HAVE CHOICE PAY

If you choose more benefits than your Choice Pay will cover, you will pay the additional amount through payroll deduction.

Whatever you choose, you'll be the one designing your own benefits program. And choosing your benefits is only one of many Partners Benefits for Residents advantages.

THE TAX ADVANTAGE

Payroll deductions you authorize as payment for many of your benefits can be made with pre-tax dollars, resulting in lower taxes for you.

Pre-Tax Benefits: before federal, state income and Social Security taxes are withheld

- Medical, dental, vision care, Health Care and Dependent Care Accounts and long-term disability (LTD)

Pre-Tax Benefits: before federal and state income taxes are withheld

- Contributions to your voluntary Tax-Sheltered Annuity plan

Pre-Tax Benefits: before federal income tax and Social Security tax are withheld

- T-passes (up to certain limits)

After-Tax Benefits: subject to federal and state income and Social Security taxes

- Employee, spouse and dependent optional life insurance
- Accidental death and dismemberment insurance
- Medical, dental or vision coverage for a same-sex domestic partner and his/her dependent children

MEDICAL

DETERMINING YOUR MEDICAL COVERAGE NEEDS

Selecting medical coverage is one of the most important financial decisions you will make in designing your personal Partners Benefits for Residents program. For many people, medical coverage is the most highly-valued benefit. But which medical plan is best for you? That depends on many factors.

- What are your anticipated medical expenses for the coming year?
- How much can you pay toward these expenses in deductibles, copayments and coinsurance?
- What is the most you could afford if you or a dependent needed health care?
- Can you opt out of medical coverage because you have coverage elsewhere — for example, through your spouse's employer?
- Is your current doctor on the list of participating physicians in Partners Plus, Partners Value, or one of the HMOs?
- Would you be willing to have your primary care physician direct all of your medical care needs?
- Could you withstand unexpectedly high medical expenses if you were to elect a high out-of-pocket cost option such as Partners Value?

Your cost for coverage is also a factor.

Most employees who are not eligible for coverage elsewhere look for full medical coverage. For this reason, you are encouraged to study the medical plans comparison chart available from the Benefits Office.

PARTNERS BENEFITS FOR RESIDENTS OFFERS SIX MEDICAL PLANS:

- Partners Plus
- Partners Value
- Master Health Plus
- Harvard Pilgrim HealthCare
- Neighborhood Health Plan
- Tufts Total Health Plan

COVERAGE LEVELS

You have the option of choosing medical coverage in the following categories:

- Employee
- Employee and child(ren)
- Employee and spouse
- Family

Under Partners Benefits for Residents, it is intended that all residents will have medical coverage, either through Partners or under another plan available to you. You will not have an opportunity to change this default coverage until the next annual open enrollment period for coverage effective the following January 1.

Take the time to review our point-of-service plans (Partners Plus or Partners Value) HMO Blue provider directory, if you haven't done so already. Partners Plus uses a broad network including our own physicians and all our affiliated hospitals. If a point-of-service plan with your primary care physician (PCP) coordinating your care and speciality referrals appeals to you, we encourage you to seriously consider our custom designed product, Partners Plus. Remember: you and your spouse can choose different PCPs if you wish, and you can choose a pediatrician as your children's PCP. It would be possible for a family of four to use four different PCPs.

Then, as with all benefit options, look at your Personal Benefits Summary or rate sheet.

- Choose your coverage level.
- Evaluate the cost for each plan included with your enrollment materials.
- Review your medical plan comparison chart.
- Weigh the level of benefits against the cost.
- Choose a medical plan within 30 days of the date you are first eligible.

If you do not elect medical coverage within your 30-day election period or indicate that you have alternative coverage, you will automatically be enrolled in Partners Value, for employee only coverage.

TERMS TO UNDERSTAND

COPAY — The amount you pay per service received, such as office visits, emergency care, prescription drugs, etc. Copays usually range from $5 to $50.

DEDUCTIBLE — The amount you pay before a plan pays any benefits. For example, if you receive out-of-network care under Partners Plus, you would have to pay $200 (for an individual) or $400 (for a family) before the plan would pay any benefits.

COINSURANCE — The plan's share of the charges that are paid after you have met any deductible. If a plan pays 80%, for example, you would pay the remaining 20%, up to the plan's annual out-of-pocket maximum.

OUT-OF-POCKET MAXIMUM — The most you would have to pay in deductibles and coinsurance in a calendar year before a plan pays 100% of covered services. Under Partners Value, for example, your out-of-pocket maximum is $2,000 per individual and $4,000 per family when you receive care in the network. After you reach your maximum, including your deductible and copayments, the plan would pay 100% of all remaining covered expenses you incur during the year.

CALENDAR-YEAR MAXIMUM — The most a plan will pay in a calendar year for a certain benefit for each covered person.

TYPES OF MEDICAL PLANS

Partners offers a variety of medical plans from which to choose. Although most people view increased choice as a positive thing, it can also make your decision-making more confusing. This overview should help you better understand your medical plan options.

The spectrum of options includes managed care plans and traditional indemnity plans. The major benefit difference between managed care and indemnity plans is that managed care generally provides more coverage for routine and preventive services.

With the exception of Partners Value (which has a larger deductible than any of the other options), all plans provide comparable coverage for diagnostic and treatment services, with low out-of- pocket costs. For most people, the level of benefits provided under each plan should not be a major consideration, since most plans offer comparable coverage. If you frequently use certain services, however, you should review the plans carefully for benefits provided for those services or call the Benefits Office for assistance with your decision-making.

An increasingly important factor for you to consider is how and where you receive care, as well as the size and scope of the provider network. Managed care plans put together a network of hospitals, physicians and other health care professionals to provide your care. Under these plans, you select a primary care physician (PCP) to coordinate all health care. All the managed care plans Partners offers maintain large provider networks, and, if you already have a PCP, you may find your doctor in more than one plan. The Partners Plus network includes not only BWH and MGH providers but also the entire HMO Blue network.

PARTNERS PLUS AND PARTNERS VALUE

With Partners Plus and Partners Value, you enjoy the benefits of a managed care plan – access to cost-effective, high-quality care – with the freedom of choice of an indemnity plan. For many employees, these programs offer the right combination of coverage, freedom of provider choice and affordability.

PARTNERS PLUS + PARTNERS VALUE

Point-of-service (POS) plans such as Partners Plus and Partners Value offer you the best of both HMO and indemnity plan coverage. You may use a POS plan just as you would an HMO, receiving care from network providers under the direction of your PCP. Or, you have the freedom of choice to receive care from a non-network provider, without your PCP's referral, at reduced benefit levels.

A special provision of Partners Plus and Partners Value allows your PCP to refer you to BWH or MGH for specialty care, regardless of where your PCP practices, at full benefit levels.

When choosing your medical plan, consider this: BWH and MGH have satellite locations in many communities. For the most cost-effective access to world-class specialists at BWH and MGH, choose Partners Plus or Partners Value.

Point-of-service (POS) plans such as Partners Plus and Partners Value offer you the best of both HMO and indemnity plan coverage. You may use a POS plan just as you would an HMO, receiving care from network providers under the direction of your PCP. Or, you have the freedom of choice to receive care from a non-network provider, without your PCP's referral, at reduced benefit levels.

Your choice of a PCP generally determines which hospitals and specialists within the network will be available to you, and only your PCP can refer you to other providers if you wish to remain in the network.

After balancing all the factors, many employees have concluded that a point-of-service plan is the choice that best meets their needs.

COVERAGE HIGHLIGHTS

POINT-OF-SERVICE PLANS

Partners Plus

In-Network

- No annual deductible. Plan pays 100% of most covered expenses
- 100% coverage for inpatient services
- $10 copay for office visits and hospital outpatient visits
- $10 copay for routine physicals for adults and children

Out-of-Network

- $200 annual deductible per individual, $400 per family
- 80% coverage for most services
- Maximum annual employee out-of-pocket cost: $2,000 per individual, $4,000 per family

Partners Value

In-Network

- $250 annual copay per person for inpatient admissions
- 80% coverage for inpatient services
- $20 copay for office visits and hospital outpatient visits
- $20 copay for routine physicals for adults and children
- Maximum annual employee out-of-pocket cost: $2,000 per individual, $4,000 per family (excludes annual $250 per person inpatient copayment)

Out-of-Network

- $600 annual deductible per individual, $1,000 per family
- 70% coverage for most services
- Maximum annual employee out-of-pocket cost: $4,000 per individual, $8,000 per family (excludes annual $250 per person inpatient copayment)

INDEMNITY PLANS

Master Health Plus

- No annual deductible. Plan pays 100% for most covered services
- 100% coverage for inpatient services
- $10 copay for office visits excluding routine physicals; $25 copay for hospital outpatient visits

HEALTH MAINTENANCE ORGANIZATIONS

Harvard Pilgrim HealthCare

- No annual deductible
- 100% coverage for inpatient services at affiliated hospitals
- $10 copay for office visits and outpatient visits

Neighborhood Health Plan

- No annual deductible
- 100% coverage for inpatient services at affiliated hospitals
- $5 copay for office visits

Tufts Total Health Plan

- No annual deductible
- 100% coverage for authorized inpatient services
- $10 copayment for office visits and outpatient visits

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If you enroll in a medical plan, you will receive a separate Merck-Medco identification card for your prescription drug coverage, and a kit listing participating pharmacies and non-preferred brand-name drugs.

PRESCRIPTION DRUG COVERAGE

When you need to fill a prescription, you can go to any pharmacy that participates with the Merck-Medco network and show your pharmacy identification card.

Prescription drug coverage is provided by Merck-Medco based on an open formulary. A formulary is a list of covered prescriptions. The vast majority of therapeutic drugs are included in the formulary. Non-therapeutic drugs, such as those used for cosmetic reasons, are not included.

Co-payments are designed to promote the use of equally-effective, less expensive medications where clinically appropriate. Co-payments are based on the drug's designation in the formulary – generic, preferred, or non-preferred brand-name. This designation is based on the recommendations of the Drug Therapy Committee of the MGH/MGPO and the Pharmacy and Therapeutics Committee of BWH. The existing formulary list is reviewed each year.

	FILLED AT RETAIL PHARMACY (UP TO 30-DAY SUPPLY)	FILLED AT RETAIL PHARMACY (UP TO 60-DAY SUPPLY)	FILLED ONLINE OR BY MAIL ORDER (UP TO 90-DAY SUPPLY)
Generic	$5	$10	$10
Preferred Brand	$10	$20	$20
Non-Preferred Brand	$25	$50	$50

OPT-OUT

- Decline medical benefits by indicating your other coverage on your election form
- Apply Choice Pay toward purchase of other benefits, or take as cash

If you are eligible for coverage under another medical plan, consider whether that coverage is adequate and cost-effective. Opting out of medical coverage, provided you are covered elsewhere, could make sense for you.

SELECTING YOUR PRIMARY CARE PHYSICIAN (PCP)

A special provision of Partners Plus and Partners Value allows your PCP to refer you to BWH or MGH for specialty care, regardless of where your PCP practices, at full benefit levels.

If you enroll in Partners Plus, Partners Value or any of the HMOs, you must select a PCP for yourself and for each family member. If you do not select a PCP, you will not be able to take advantage of your coverage, so it is very important that you complete the PCP selection form for the plan you select.

If you would like help in selecting a primary care physician, help is available. Call the BWH Physician Referral Service for assistance at (617) 732-8288 or the MGH Physician Referral Service at (617) 726-5800.

If you find it more convenient to choose a PCP close to home, you'll find Partners affiliates and PCHI affiliates in many Massachusetts communities: Brigham and Women's Hospital; Faulkner Hospital; Massachusetts General Hospital; Newton-Wellesley Hospital; North Shore Medical Center: North Shore Children's Hospital; Salem Hospital; and Union Hospital.

DENTAL

DETERMINING YOUR DENTAL COVERAGE NEEDS

The two plans offer different benefits, so be sure to review each plan carefully. Then select the plan that's best for you.

Whether or not you need dental coverage depends on several factors. Your family's dental history is one of the most important of these.

Look at the benefits available under the two plans. Then check your Personal Benefits Summary or rate sheet for price.

To make the right decision, ask yourself these questions:

- What is your own dental history?
- Do you or does a member of your family need special or recurring treatment such as orthodontia or periodontics?
- Do you need coverage for yourself only or for your family?
- Are you covered elsewhere or could you be?
- Do you need only routine check-ups? Do you often need fillings and crowns?
- How much did you and other family members spend on dental care last year?

PARTNERS BENEFITS FOR RESIDENTS OFFERS TWO DENTAL PLANS:

- Major Dental
- Basic Dental

COVERAGE LEVELS

You have the option of choosing dental coverage in the following categories:

- Employee
- Employee and child(ren)
- Employee and spouse
- Family

COVERAGE HIGHLIGHTS

Before you receive any dental care, be sure that your dentist participates with Delta Dental so that you receive the highest level of coverage payable under the Plan. Most Massachusetts dentists participate with Delta Dental.

MAJOR DENTAL

The plan pays 100% of the charges for diagnostic and preventive care which includes a checkup and cleaning every six months. Then:

- After you pay a $25 annual deductible ($50 per family), the plan will pay:
- 80% of the charges for minor restorative treatment
- 50% of the charges for major restorative treatment
- Maximum benefit: $2,000 per person annually
- Orthodontia benefit (for children only): 50% coverage, no deductible, the plan will pay a lifetime maximum benefit of $1,500 per child under age 19.

BASIC DENTAL

The plan pays 100% of the charges for diagnostic and preventive care which includes a checkup and cleaning every six months. Then:

- After you pay a $50 annual deductible ($100 per family), the plan will pay:
- 50% of the charges for minor restorative treatment
- 50% of the charges for major restorative treatment
- Maximum benefit: $1,000 per person annually

No orthodontia coverage is available under Basic Dental.

See the chart on the next page for specific age limitations for certain services. For more information on dental plan coverage, call 1-800-451-1249.

DENTAL SERVICES Calendar Year Maximum	MAJOR DENTAL $2000 per person excluding orthodontia	BASIC DENTAL $1,000 per person
Diagnostic/Preventive Services		
Complete Initial Exam and Charting – once		
Recall exams once every six months		
X-Rays: full mouth – every 60 months;		
bitewings – every 12 months for adults,		
every six months for children under age 19		
Single tooth X-rays as needed		
Models and casts – every 60 months		
Preventive Services		
Cleaning, scaling, polishing – every six months		
Fluoride treatment – every six months for members under age 19		
Space maintainers – for members under age 19		
Sealants for unrestored permanent molars,		
once every 48 months for children under age 14		
Minor Restorative	100% Coverage No Deductible	100% Coverage No Deductible
Restorative Services		
Amalgam (metal) fillings – once every 12 months per surface, per tooth		
Synthetic fillings – once every 12 months per surface,		
per tooth for front teeth only		
Temporary fillings – once per tooth		
Stainless steel crowns (baby teeth only) – once every 24 months per tooth		
Oral Surgery	After a $25 Individual Annual Deductible, $50 Family, 80% Coverage	After a $50 Individual Annual Deductible, $100 Family, 50% Coverage
Simple extractions (non-surgical) in dentist's office		
Surgical extractions (including impactions) in dentist's office		
(If surgery provided in surgical day care or hospital patient must seek		
benefits from medical insurance)		
Periodontics		
Periodontal prophylaxis – once every three months following active treatment		
Scaling of inner gum pockets – once every 24 months		
Gingivectomy – in dentist's office (if gingivectomy performed in surgical day		
care or hospital, patient must seek benefits from medical insurance)		
Endodontics		
Root canal therapy – once per tooth		
Pulpotomy – to age 14		
Prosthetic Maintenance		
Denture repairs – once every 12 months, some repair		
Reline of dentures – once every 36 months		
Recementing crowns, inlays and onlays – once every 12 months per tooth		
Emergency Dental Care		
Palliative treatment – three times in six months		
General Anesthesia (only with covered surgical services)		
Major Restorative	50% Coverage After Plan Deductible	50% Coverage After Plan Deductible
Prosthodontics		
Dentures		
Fixed bridges and crowns (when part of a bridge) – once every 60 months		
Restorative Services		
Crowns, inlays, onlays (when teeth cannot be restored with regular fillings)		
– once every 60 months per tooth		
Orthodontia	50% coverage, no deductible $1,500 per child under age 19	not available N/A
Active orthodontic treatment for children (up to age 19)		
Lifetime orthodontia maximum		

VISION

DETERMINING YOUR VISION CARE COVERAGE NEEDS

For most of us, the cost for vision care is a predictable need. The Vision Care Plan provides a way to pay these expenses at a lower cost through a network of optometrists.

Vision care is necessary to maintain good health. Periodic vision examinations not only determine the need for corrective eyewear, but also may detect the presence of general health problems in their early stages. With the Vision Care Plan, the costs for these services are low and the benefits great. Ask yourself these questions:

- What are your anticipated vision care expenses for the coming year?
- Would you be willing to use a network of private optometrists for your vision care services?

PARTNERS BENEFITS FOR RESIDENTS OFFERS ONE OPTION:

- Vision Care Plan

COVERAGE LEVELS

You have the option of choosing vision care coverage in the following categories:

- Employee
- Employee and child(ren)
- Employee and spouse
- Family

COVERAGE HIGHLIGHTS

[illegible]

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HERE IS AN OVERVIEW OF VISION PLAN BENEFITS.

PLAN PROVISION	IN-NETWORK PROVIDER		OUT-OF-NETWORK PROVIDER	
Eye Exams	100% after you pay $10 annual deductible		Covered up to $16	
Eyeglasses or Contact Lenses	One pair of eyeglasses or contact lenses covered in full		Reimbursement Levels:	
	– Eyeglass frames from Davis Designer selection	100%	– Frames	$14
	Vision lenses:		One pair of lenses:	
	– Single lenses		– Single lenses	$14
	– Bifocal lenses		– Tinted lenses	$14
	– Trifocal lenses		– Bifocal lenses	$23
	– Contact lenses after you pay $25-$45 for standard, soft daily-wear, disposable or planned replacement contact lenses*	100%	– Trifocal lenses One pair of contact lenses	$32 $45
Coverage Frequency	Once every 12 months		Once every 12 months	

The plan also covers glass gray #3 prescription lenses and photogray Extra® PGX (sun-sensitive)

* Your Davis Vision provider will give you specific copayment information for the type of lenses you require or prefer.

LONG-TERM DISABILITY

DETERMINING YOUR LONG-TERM DISABILITY NEEDS

If you were disabled and unable to complete your residency or to work for a long period of time:

- How would you pay for food, housing and current monthly bills?
- How would you pay for medical coverage or continue benefits for dental and vision care?
- How would you continue to pay your student loans?

By enrolling for Long-Term Disability coverage, if you become disabled you will receive a monthly income and your medical, dental, vision and basic life insurance coverage will continue. The plan will also pick up the cost of required student loan payments while you're disabled, subject to a $150,000 maximum. In addition, this program includes a unique feature that protects you against future income loss should you become disabled. This feature allows you to increase coverage upon completion of your residency to more realistically reflect your earning capacity based on your specialty.

Most residents cannot afford to be without this excellent coverage.

PARTNERS BENEFITS FOR RESIDENTS OFFERS TWO OPTIONS:

- Long-Term Disability (LTD) Plan – 60% of pay
- Long-Term Disability (LTD) Plan – 80% of pay

COVERAGE LEVEL

- Employee

COVERAGE HIGHLIGHTS

- Immediate eligibility, upon completing and returning your benefits enrollment form within the first 30 days of benefits eligibility.
- After being disabled for three months, you'll receive 60% or 80% of your pay with a 3% annual cost-of-living adjustment, if applicable.
- Benefits continue for as long as you remain disabled or until you reach age 65. (If you are age 60 or older when you become disabled, benefits continue for up to five years.)
- If you become disabled during your residency and remain disabled until the time you were scheduled to complete your residency, your benefit is adjusted to reflect 60% of the first-year earnings for your specialty.
- Upon completing your residency, you may elect to continue your coverage.
- Upon completing your residency, you may increase your coverage, based on 70% of your projected first-year earnings, to a maximum of $8,000 per month, without evidence of insurability and to $25,000 per month with the excess over $8,000 per month subject to medical and financial underwriting.

Refer to the separate long-term disability summary plan description for more details.

If you elect coverage after the open enrollment period, an evidence of good health form must be approved before coverage can begin.

LIFE INSURANCE

DETERMINING YOUR OPTIONAL LIFE INSURANCE NEEDS

Everyone has different needs for life insurance. For some, the basic benefit is enough. Others need more insurance to help their survivors. To determine how much life insurance you need, ask yourself these questions:

- Does someone besides yourself count on your income?
- Do you have children who will require your assistance to pay for their education?

If the answer to any of these questions is yes, consider your options to buy additional coverage at very attractive group rates.

PARTNERS OFFERS THESE PROGRAMS:

- Employee Basic Life Insurance
- Employee Optional Term Life Insurance and AD&D Insurance
- Spouse Term Life Insurance
- Dependent Term Life Insurance

COVERAGE LEVELS

Basic Life and AD&D Insurance

- Employee

Optional Life and AD&D Insurance

- Employee
- Spouse
- Dependent Child(ren) (for Life only)

COVERAGE HIGHLIGHTS

Partners provides you with life insurance:

- Core basic employee life insurance and AD&D insurance of 1x your annual salary (up to $500,000 on each)

In addition, Partners also offers:

Employee

- Optional term life insurance 1x, 2x, 3x, 4x, 5x your annual salary (maximum of $1,000,000) in each program. Newly eligible employees can elect up to 3x salary in optional life insurance, not to exceed $250,000, without providing proof of good health. During open enrollment, you may elect to increase your life insurance coverage by 1x your annual salary (if your annual salary is less than or equal to $150,000) without providing proof of good health.
- Optional AD&D insurance amounting to $100,000

Spouse (no proof of good health required)

- Term life insurance amounting to: $10,000, $25,000, $50,000, $75,000 or $100,000 in each program
- Optional AD&D insurance amounting to $100,000

Dependent child(ren) (no proof of good health required)

- Term life insurance $10,000/child no matter how many dependent children you have

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TAX SAVER ACCOUNTS

DETERMINING YOUR NEED FOR A HEALTH CARE ACCOUNT

Tax Saver Accounts let you take advantage of laws that allow you to save on taxes for certain health care and dependent care expenses. There are two separate accounts – one for health care expenses not covered by your medical, dental or vision plans, and one for dependent care expenses.

To determine the level of eligible expenses you are likely to incur, review what you have spent on medical care for the last two years and what you expect to spend in the coming months. You should consider how you choose to participate in a particular benefit plan – such as medical, dental or vision care coverage – may affect the amount you might contribute to a Health Care Account. The following examples of eligible expenses may help you determine what types of unreimbursed medical expenses you may claim with your Health Care Account. In general, most health care expenses (medical, dental, vision, hearing, etc.) can be paid through your Health Care Account.

The IRS does not recognize your same-sex domestic partner and his/her children as dependents for tax purposes. As a result, their expenses are not eligible for reimbursement through a Health Care Account.

DETERMINING YOUR NEED FOR A DEPENDENT CARE ACCOUNT

A Dependent Care Account allows you to set aside tax-free income to pay for dependent care in order for you and your spouse to work.

- An eligible dependent is an individual who is claimed on your tax return as your dependent and who is a child under the age of 13, or a person who is physically or mentally incapable of caring for his or her own needs, regardless of age.
- If you claim the dependent care credit on your tax return or collect compensation through your Dependent Care Account, you must report the name, address and taxpayer identification number of each dependent care provider. If you do not comply, you will either lose the credit or pay taxes on the income placed in your Dependent Care Account.

PARTNERS BENEFITS FOR RESIDENTS OFFERS TWO OPTIONS:

- Health Care Account
- Dependent Care Account

PARTICIPATION HIGHLIGHTS – HEALTH CARE SPENDING ACCOUNT

Up to $3,000 can be set aside each year to pay for uninsured medical, dental and vision expenses with before-tax dollars.

PARTICIPATION HIGHLIGHTS – DEPENDENT CARE SPENDING ACCOUNT

Up to $5,000 tax-free per year can be set aside to pay for dependent care.

EXAMPLES OF ELIGIBLE EXPENSES

Remember: with the range of medical, dental and vision plans available under Partners Benefits for Residents, some of these expenses may be partially or fully covered depending upon your personal selections. Any amount covered by your plans and your cost for coverage under Partners Benefits for Residents are not eligible expenses.

To be reimbursed for your eligible expenses, get a form from the Benefits office by calling (617) 726-8133, or e-mail Benefits,Information or go to the Partners intranet at http://is.partners.org/hr/

EXAMPLES OF ELIGIBLE EXAMPLES

DENTAL CARE – all uncovered dental care including deductibles, coinsurance, and amounts over maximums

VISION CARE – all vision aids and exams not covered by a plan, laser vision correction treatment

HEARING CARE – exams not covered by a medical plan, hearing aids and batteries

PRESCRIPTION DRUGS – not covered by a medical plan, copayments

OUTPATIENT PSYCHIATRIC CARE – in excess of your plan's benefit maximum

HEALTH CARE – deductibles, copayments, coinsurance, regular check-ups, and other expenses not covered by a plan (as long as they meet the criteria for the federal income tax deduction), including:

- Prosthetic and orthopedic devices
- Special medical equipment
- Psychological or psychiatric care
- Occupational therapy
- Acupuncture
- Chiropractic care
- Nursing services
- Other health care expenses such as annual physicals, immunizations and vaccinations

DECIDING

HOW MUCH TO SET ASIDE IN YOUR DEPENDENT CARE ACCOUNT

Before you decide how much to contribute to your Dependent Care Account, it is important to consider:

- Holidays and vacations during which your dependent care needs might change;
- Whether one of your dependents will begin school during the plan year and need less dependent care; and
- Whether any of your dependents will become ineligible for care during the year (for example, by turning age 13).

To qualify, your dependent care expenses can't exceed the earned income, if married, of the lesser-earning spouse.

TAX CREDIT OR REIMBURSEMENT ACCOUNT?

Before enrolling in the Dependent Care Account, you should evaluate whether the tax credit you can take on your federal income tax 1040 form will save you more money than the Dependent Care Account. Which method is best for you will depend on your income, your spouse's income, how much you pay for dependent care, your tax bracket, and the number of dependents you have.

Any expenses reimbursed through a Dependent Care Account cannot be claimed on your federal tax return.

Generally speaking, the lower your income, the more value to you of a tax credit on your annual tax return. A tax deduction, such as that available through the Dependent Care Account, is of more value as your income goes up.

The IRS does not recognize your same-sex domestic partner and his/her children as dependents for tax purposes. As a result, their expenses are not eligible for reimbursement through a Dependent Care Account.

USE IT OR LOSE IT

Be sure to estimate your health care and dependent care expenses carefully. Under IRS rules, you must forfeit any unused account balance(s) remaining at year end. Generally, you cannot change or stop contributing during the year unless you have a qualified change of status. You have until March 31st of the subsequent year to submit for reimbursement any expenses you incurred before the end of the previous calendar year.

For a more detailed explanation of medical and dependent care reimbursement accounts, refer to IRS publications 502 and 503. You may request a copy from the Benefits Office by using our e-mailbox: Benefits,Information or by calling 726-8133 and leaving your request in our forms mailbox. Or, you can go to the IRS website (http://www.irs.ustreas.gov/prod/forms_pubs/pubs.html) and print off a copy.

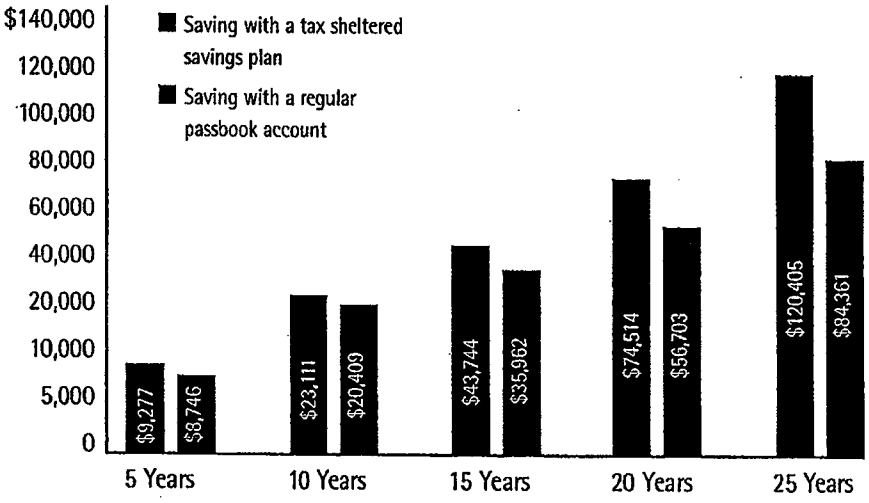
For a complete list of eligible expenses, go to the IRS website (http://www.irs.ustreas.gov/prod/forms_pubs/pubs.html) and print off the publications.

TAX-SHELTERED ANNUITY

Experts tell us that to live comfortably in retirement, we need at least 70% to 80% of the income that we earn just before we retire. This is known as the income replacement ratio. The Tax-Sheltered Annuity program allows you to set aside up to $10,500 a year on a before-tax basis (subject to other federally-mandated limits). Over the years, your savings can really grow because of the benefits of compounding and tax-deferred savings.

THE POWER OF TAX-DEFERRED SAVINGS

Consider the advantages of tax-deferred savings over regular after-tax savings. Let's say that this employee saves $29 a week, or $1,508 a year. For this illustration we will assume that she earns an annual return of 8% and is in the 28% tax bracket.



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As you can see, over time your savings can really benefit from the power of tax-deferred savings. A variety of investment options is available ranging from conservative fixed income funds to aggressive stock funds. For more information, call your dedicated service representative.

WHY START SAVING NOW?

For many people, retirement seems like such a distant goal that they feel no urgency to plan so far ahead. After all, how much can it hurt to wait a few more years?

The chart below shows the real cost of waiting. It compares two 29-year-old co-workers, Dana and Pat. Dana put away $2,000 a year for 10 years (earning a hypothetical 8% rate of return) *and then never added another dime to her savings.* Pat waited 10 years to start, then invested $2,000 a year until she retired 27 years later at age 65. *Dana invested a total of $20,000 while Pat contributed $54,000.* Who came out ahead? You might be surprised.

	DANA		PAT	
AGE	INVESTMENT	YEAR-END VALUE	INVESTMENT	YEAR-END VALUE*
29	$2,000	$ 2,160	0	0
30	2,000	4,493	0	0
31	2,000	7,012	0	0
32	2,000	9,733	0	0
33	2,000	12,672	0	0
34	2,000	15,846	0	0
35	2,000	19,273	0	0
36	2,000	22,975	0	0
37	2,000	26,973	0	0
38	2,000	31,291	0	0
39	0	33,794	$2,000	$ 2,160
40	0	36,498	2,000	4,493
41	0	39,418	2,000	7,012
42	0	42,571	2,000	9,733
43	0	45,977	2,000	12,672
44	0	49,655	2,000	15,846
45	0	53,627	2,000	19,273
46	0	57,917	2,000	22,975
47	0	62,551	2,000	26,973
48	0	67,555	2,000	31,291
49	0	72,959	2,000	35,954
50	0	78,796	2,000	40,991
51	0	85,099	2,000	46,430
52	0	91,907	2,000	52,304
53	0	99,260	2,000	58,649
54	0	107,201	2,000	65,800
55	0	115,777	2,000	72,900
56	0	125,039	2,000	80,893
57	0	135,042	2,000	89,524
58	0	145,845	2,000	98,846
59	0	157,513	2,000	108,914
60	0	170,114	2,000	119,787
61	0	183,723	2,000	131,530
62	0	198,421	2,000	144,212
63	0	214,295	2,000	157,909
64	0	231,438	2,000	172,702
65	0	249,953	2,000	188,678
TOTAL AMOUNT INVESTED	$20,000		$54,000	
ACCOUNT VALUE AT AGE 65		$249,953		$188,678

(For illustration purposes only. Your investment experience will differ.)

* Assumes return of 8% per year compounded annually.

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PART 2:
ENROLLMENT INFORMATION

The amount of Choice Pay available to you is shown on your Personal Benefits Summary at open enrollment or rate sheet, if you are newly eligible for benefits. Your Choice Pay will vary according to the Choice Pay formula (see page 5) and according to your benefit choices. You are encouraged to review this guide, which provides highlights of all available plans.

HOW THE ENROLLMENT PROCESS WORKS

Enrollment Period

During open enrollment, use the web or telephone enrollment system described on your Personal Benefits Summary. Please refer to your Personal Benefits Summary for specific open enrollment dates.

Newly Eligible Residents

As part of your Resident's orientation you'll receive benefits enrollment materials, including a benefits enrollment form, and have the opportunity to ask questions.

ENROLLMENT INSTRUCTIONS

On the following page you will see a Practice Worksheet. Using your Personal Benefits Summary and rate sheet, you can pencil in pricetags and Choice Pay to consider a variety of scenarios. If you are newly eligible for Partners Benefits for Residents, use your rate sheet and benefits enrollment form.

When you have designed the coverage package that best meets your needs, simply enter your choices in the appropriate area of your benefits enrollment form. During the open enrollment period you can enroll online. Send your completed benefits enrollment form to the Benefits Office within 30 days of your eligibility period. **Remember: if we do not receive your response within 30 days of the date your appointment begins, you will be assigned employee-only medical coverage under Partners Value.** You will not have an opportunity to change your coverage until the next annual open enrollment period for coverage effective the following January 1.

USING THE PRACTICE WORKSHEET

If you're interested in testing out choices, you can use the Practice Worksheet.

To make it work for you, line up your rate sheet and benefits enrollment form alongside the worksheet.

- Before enrolling, complete the practice exercise in your guide, where you will enter your choices, the pricetags for your selections and the totals.
- Once you are satisfied with your decisions, it is time to enroll.

NOTE: Your Practice Worksheet and rate sheet are not enrollment forms.

PRACTICE WORKSHEET

On your Personal Benefits Summary or benefits enrollment form and rate sheet, circle the plans and levels of coverage you want, then enter the pricetags on this worksheet.

Enter basic Choice Pay	$_____
Enter medical participation Choice Pay based on level of coverage you choose (enter 0 if you are not electing Partners medical coverage)	$_____
Enter dental participation Choice Pay based on level of coverage you choose (enter 0 if you are not electing Partners medical coverage)	$_____
Enter Total Choice Pay	A $_____

Enter prices for options you choose	Column 1	Column 2
Enter Medical Pricetag	$_____	$_____
Enter Dental Pricetag	$_____	$_____
Enter Vision Pricetag	$_____	$_____
Enter Long-Term Disability Pricetag	$_____	$_____
Enter Employee Optional Life Pricetag	$_____	$_____
Enter Spouse Optional Life Pricetag	$_____	$_____
Enter Child Optional Life Pricetag	$_____	$_____
Enter Employee AD&D Insurance Pricetag	$_____	$_____
Enter Spouse AD&D Insurance Pricetag	$_____	$_____
Enter Tax Saver Account Amounts:		
Health Care Account Contribution (monthly)	$_____	$_____
Dependent Care Account Contribution (monthly)	$_____	$_____
Add prices for total	B $_____	$_____
If B is larger than A	B $_____	B $_____
	-A $_____	-A $_____
	Your Costs $_____	$_____
If A is larger than B	A $_____	A $_____
	-B $_____	-B $_____
	Your Cash $_____	$_____

YOUR COBRA RIGHTS

When you or your covered dependents are no longer eligible for coverage under your medical, dental, vision care plan or your health care account, you or your covered dependents may be eligible to continue this coverage as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA).

To continue your coverage (or your dependents' coverage), you will pay up to 102% of the premium cost. This law applies to you if you lose eligibility for coverage due to:

- Termination of employment (for reasons other than gross misconduct);
- Reduction of work hours;
- Divorce or legal separation;
- Your death;
- Your entitlement to Medicare benefits; or
- Loss of status as an eligible dependent.

CONTACT THE BENEFITS OFFICE AT 726-8133 IF YOU HAVE ANY QUESTIONS ABOUT COBRA.

The period of COBRA coverage begins with the date of your qualifying event and continues for up to 18 months from that qualifying event in most cases. If you continue your coverage under COBRA due to divorce or loss of status as an eligible dependent, however, COBRA coverage is available for 36 months. If you are qualified for disability under Title II or Title XVI of the Social Security Act, after you accept COBRA coverage, your COBRA coverage continues for up to 29 months. You will pay up to 150% of the premium cost during the 19th through 29th months.

HOW TO ENROLL FOR COBRA CONTINUATION COVERAGE

To enroll for continuation coverage under COBRA, complete a COBRA election form which will be mailed to you upon termination from Partners or upon reduction in work hours, or which is available from the Benefits Office. Divorced spouses or individuals who lose status as eligible dependents should call the Partners Benefits Office to leave a message on the coverage continuation mailbox. Return your completed election form to the address on the form within 60 days from your date of termination of coverage or your notification of COBRA eligibility, whichever is later. If you do not return your completed form, Partners will assume that you are waiving continued coverage under COBRA, and you will not be allowed to continue your coverage in the plan. (The 60 days will be counted from the date of the COBRA eligibility notice to the postmarked date of your mailed election form.)

WHEN YOUR COBRA COVERAGE ENDS

Your COBRA coverage will end when:

- You reach the maximum length of time allowed for your COBRA coverage (for example, 18 months or 29 months or 36 months from your qualifying event). (If you are continuing your coverage beyond 18 months due to disability, your coverage will end when you are no longer disabled or after 29 months, whichever is sooner.);
- You fail to make timely payment of your COBRA premiums;
- You enroll in another employer-sponsored health care plan and that plan does not include pre-existing conditions limitations or waiting periods; or
- You become entitled to Medicare benefits.

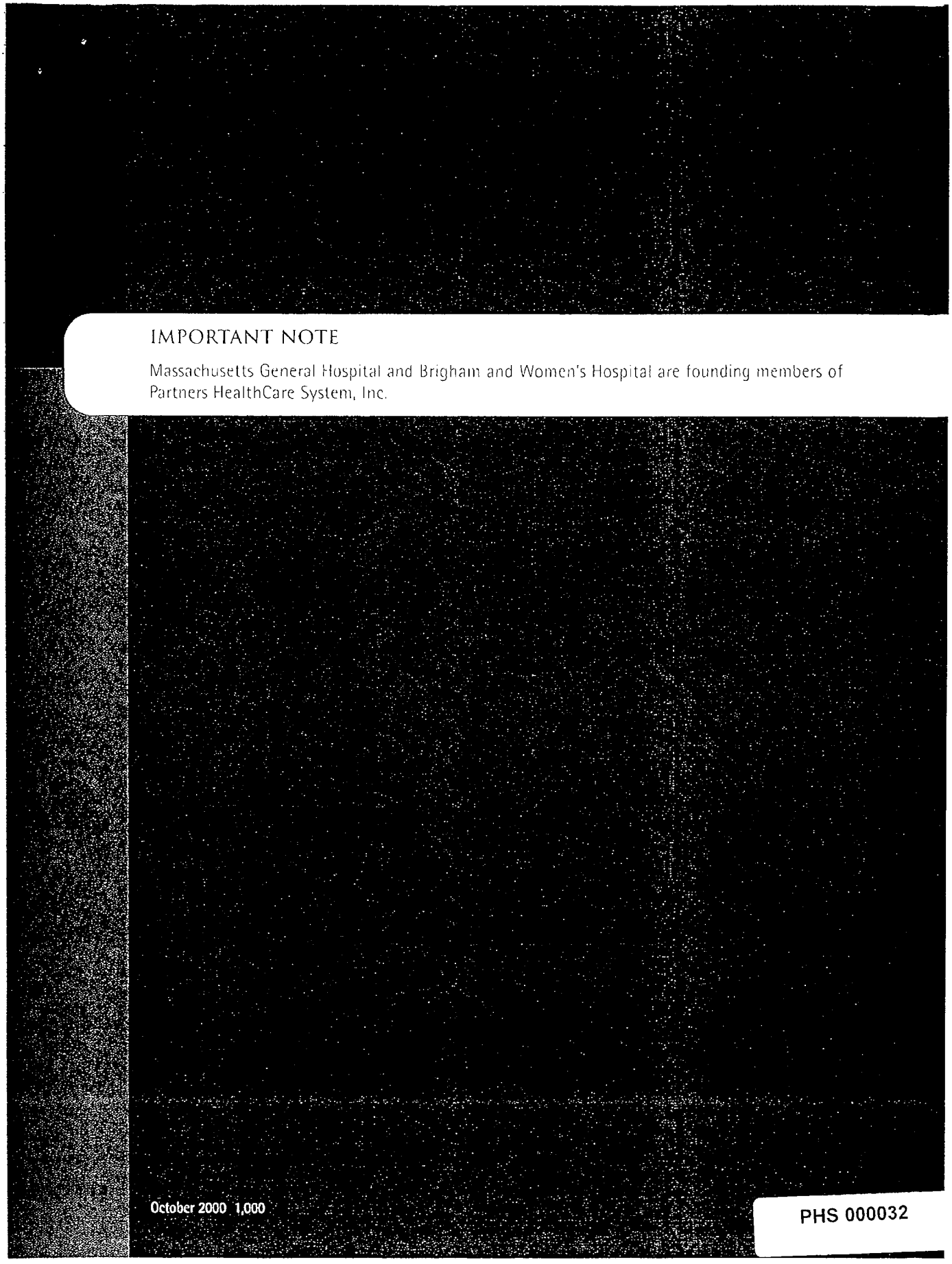
In addition, your COBRA coverage described in this guide will end when the Hospital terminates its agreement with the health care companies which administer the plans. In this case, your COBRA coverage may continue under another health care plan.

HIPAA PROVISION
IF YOU DECLINED MEDICAL COVERAGE BECAUSE YOU HAVE COVERAGE ELSEWHERE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you may have the opportunity to enroll yourself and your eligible dependents for medical coverage during the year if you previously declined coverage, as follows:

- You and/or your dependents have coverage from another source (such as your spouse's medical plan or COBRA coverage) and you lose that coverage, or
- You acquire a dependent through marriage, birth, adoption or placement for adoption.

If you need to enroll for coverage as a result of one of the above events, you must do so within 31 days of the event. Otherwise, you may be required to wait until the next open enrollment period.



IMPORTANT NOTE

Massachusetts General Hospital and Brigham and Women's Hospital are founding members of Partners HealthCare System, Inc.

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EX. 3

PARTNERS

Residents

2002

PARTNERS
HEALTHCARE SYSTEM

For Your Personal Benefit

Partners HealthCare System is pleased to offer you

PARTNERS™

Benefits for Residents

Partners Benefits for Residents will offer you the flexibility you need to design a benefits program that best suits your needs.

Prior to enrolling, we encourage you to:

- make use of this informational guide by reading through each of the benefit descriptions, or
- contact your dedicated service representative at (617) 726-8133 (then press 5 or 6) if you need help with enrollment.

The Benefits Office assigns two full-time service representatives to assist our residents and fellows. Your service representatives can be reached by calling 617-726-8133, then pressing 5 or 6, and both are available at the hospital campuses on a regular basis. At BWH, your service representative is available onsite at the Galleria in the Human Resources Office. Our MGH service representative is available at the Professional Staff Benefits Office.

Table of Contents

Highlights

Partners Benefits for Residents is designed for your personal benefit. With *Partners Benefits for Residents*, you can select the benefits that will best meet your needs and the needs of your family.

- You will be provided with Choice Pay you can use to purchase the benefits of your choice from the options available.
- You can choose from six medical plans to protect yourself and your family in the event of illness or injury. A prescription drug benefit managed by Merck-Medco offers you low co-payments and the convenience of a mail service program.
- Two dental plans offer you the level of coverage that is right for your situation.
- A vision care plan offers a cost-effective way for you to get checkups and corrective lenses.
- You can purchase different levels of coverage for medical, dental and vision care (including coverage for your qualifying same-sex domestic partner), tailoring each to best fit your special needs.
- Two Tax Saver Accounts save you tax dollars and reduce your out-of-pocket costs for health care and dependent day care.
- Long-term disability insurance, with unique features for residents, is available for financial protection in the event you cannot work due to an extended illness or injury.
- Basic group life insurance (paid by Partners) in an amount equal to your annual salary will provide protection for your survivors.
- Optional group life insurance allows you to purchase additional life insurance for yourself, your spouse or your dependents.
- Accidental death and dismemberment insurance is available to protect you and your spouse or same-sex domestic partner.

You must make your elections within 30 days of your benefits eligibility date in accordance with IRS regulations that govern the plans. **Coverage is effective on the date you become eligible.**

Information contained in this guide is a summary of the Partners Benefits for Residents Program. If there is a discrepancy between this summary and the plan documents, the plan documents will govern. Plan documents are available in the Benefits Office.

Decisions About Benefit Selections

To use *Partners Benefits for Residents* to your advantage it is necessary to understand the choices you will be making. Take a careful look at this guide, review your Personal Benefits Summary, or your rate sheet, if you are newly eligible for benefits. Use the worksheet on page 29 of this booklet — and keep the following questions in mind.

- Which medical plan is best for my family and me? Could I be covered under another medical plan and use all available Choice Pay to purchase other benefits?
- Should I buy dental coverage for myself and my family? What level of dental coverage should I choose?
- Should I buy vision care for myself and my family?
- Should I buy long-term disability coverage?
- Will I need more life insurance than one times my annual base salary?
- Do I need to buy optional life insurance for my dependents?
- Should I participate in either or both Tax Saver Accounts to pay for certain health care and dependent care expenses?
- Should I begin saving for retirement?

If you are eligible for coverage under another medical plan, you should review that coverage to avoid signing up for a benefit that you may not need. Should that be the case, you could use your Choice Pay toward the purchase of other benefits.

Eligibility

You are eligible for *Partners Benefits for Residents* if you are a resident and you:

- Have an appointment at a sponsoring institution, and
- Are a monthly-paid regular (status 1) resident scheduled to work at least 87 hours per month at a standard hospital salary of at least $833.33 per month.

Coverage is effective on the date you become eligible.

Dependent Eligibility

Your eligible dependents are your legal spouse or same-sex domestic partner and your dependent unmarried children under age 19. Unmarried children under age 25 who are full-time students are also eligible. For coverage to continue during vacation periods, the child(ren) must be scheduled to enter school the next semester. Your medical and dental plans will request proof of student status at least annually.

Unmarried dependent children of your same-sex domestic partner are also eligible for medical coverage, as long as they otherwise qualify as dependents.

Coverage for Your Same-Sex Domestic Partner

Your same-sex domestic partner may enroll for coverage on the same basis as a spouse. Throughout this guide, any reference to spousal eligibility should also be assumed to include your same-sex domestic partner, unless stated otherwise. Contact the Benefits Office for an informational packet if you are interested in coverage for your same-sex domestic partner and/or the dependent children of your same-sex domestic partner.

To be eligible for same-sex domestic partner coverage, you and your partner must be at least 18 years of age and:

- Not be married to anyone else or be the domestic partner of anyone else;
- Not be related by blood closer than would bar marriage under the law;
- Be jointly responsible for living expenses in a permanent residence that you share;
- Expect your relationship to be permanent; and
- Agree to notify the appropriate parties of any change in the circumstances of your relationship.

Dependent children of qualified same-sex domestic partners are also eligible for coverage on the same basis as step-children. Federal law prohibits you, however, from using either your Dependent Care Account or your Health Care Account to reimburse yourself for expenses incurred by your same-sex domestic partner or his/her children.

Changes After the Enrollment Period

Open enrollment in *Partners Benefits for Residents* is held annually, usually in late fall. All choices become effective on the first date of the plan year — each January 1. **Newly eligible employees have 30 days to enroll in the Partners Benefits for Residents program.**

After the enrollment deadline has passed, under IRS regulations you may not add, change or cancel your pre-tax benefit elections until the next plan year, unless you have a qualified change of status.

A qualified change of status occurs if you experience one of the following:

- Marriage or divorce
- Addition of a dependent through birth, adoption or change in custody
- Death of spouse or dependent
- Gain or loss of eligibility for Medicaid, Medicare or other group insurance
- You or your spouse change from benefits-eligible to benefits-ineligible status, or vice versa
- Your spouse's employment ends
- You move out of your HMO's service area
- Gain or loss of full-time student status for dependent age 19 to age 25

The change in coverage you request must be consistent with the change of status that you experience and must be requested within 30 days of the change of status.

Changes to your life insurance elections are allowed after open enrollment. However, adding or increasing life insurance coverage is subject to evidence of good health. Changes or new elections for LTD are allowed at open enrollment and are also subject to evidence of good health.

Part 1: Partners Benefits for Residents

Partners Benefits for Residents is a program that gives you a choice about how Partners dollars are spent on your behalf.

Partners Benefits for Residents is designed to reflect your personal choice by allowing you to select the options that best suit your needs and the needs of your family. Each year during the annual open enrollment period you get an opportunity to reassess your needs and elect your benefits for the following plan year, which begins on January 1.

Choice Pay

Each year Partners gives you Choice Pay, which you can use to purchase benefits that meet your personal needs.

There are three types of Choice Pay available under *Partners Benefits for Residents*.

Basic Choice Pay

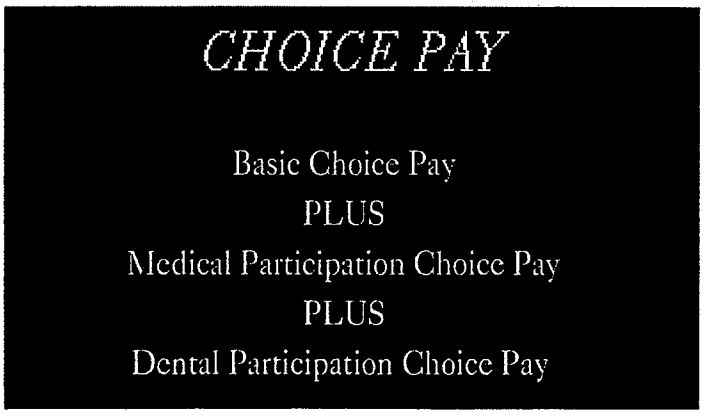
You will receive a basic amount which can be used to purchase benefits.

PLUS

Medical and/or Dental Participation Choice Pay

If you enroll in one of the medical or dental plans, you will receive an additional amount based on the level of coverage you select:

- Employee
- Employee and Children
- Employee and Spouse
- Family



Note: Actual Choice Pay amounts appear on your Personal Benefits Summary or rate sheet.

Partners Benefits for Residents benefit options include:

- Six medical plans
- Two dental plans
- A vision care plan
- A long-term disability plan
- Basic group life insurance coverage
- An optional life insurance plan
- Accidental death and dismemberment coverage
- Two Tax Saver Accounts

If You Have Extra Choice Pay

If you have extra Choice Pay that you do not wish to use for benefits, it can be taken in cash as additional taxable pay (provided you are covered under a medical plan).

If You Choose More Benefits Than You Have Choice Pay

If you choose more benefits than your Choice Pay will cover, you will pay the additional amount through payroll deduction.

Whatever you choose, you'll be the one designing your own benefits program. And choosing your benefits is only one of many Partners Benefits for Residents advantages.

The Tax Advantage

Payroll deductions you authorize as payment for many of your benefits can be made with pre-tax dollars, resulting in lower taxes for you.

Pre-Tax Benefits: before federal, state income and Social Security taxes are withheld

- Medical, dental, vision care, Health Care and Dependent Care Accounts and long-term disability (LTD)

Pre-Tax Benefits: before federal and state income taxes are withheld

- Contributions to your voluntary Tax-Sheltered Annuity plan

Pre-Tax Benefits: before federal income tax and Social Security tax are withheld

- T-passes (up to certain limits)

After-Tax Benefits: subject to federal and state income and Social Security taxes

- Employee, spouse and dependent optional life insurance
- Accidental death and dismemberment insurance
- Medical, dental or vision coverage for a same-sex domestic partner and his/her dependent children

Medical

Partners Benefits for Residents offers six medical plans:

- Partners Plus
- Partners Value
- Master Health Plus
- Harvard Pilgrim HealthCare
- Neighborhood Health Plan
- Tufts Total Health Plan

You may:

- Opt out of medical coverage

Coverage Levels

You have the option of choosing medical coverage in the following categories:

- Employee
- Employee and Children
- Employee and Spouse
- Family

Determining Your Medical Coverage Needs

Selecting medical coverage is one of the most important financial decisions you will make in designing your personal *Partners Benefits for Residents* program. For many people, medical coverage is the most highly-valued benefit. But which medical plan is best for you? That depends on many factors.

- What are your anticipated medical expenses for the coming year?
- How much can you pay toward these expenses in deductibles, copayments and coinsurance?
- What is the most you could afford if you or a dependent needed health care?
- Can you opt out of medical coverage because you have coverage elsewhere — for example, through your spouse's employer?
- Is your current doctor on the list of participating physicians in Partners Plus, Partners Value, or one of the HMOs?
- Would you be willing to have your primary care physician direct all of your medical care needs?
- Could you withstand unexpectedly high medical expenses if you were to elect a high out-of-pocket cost option such as Partners Value?

Your cost for coverage is also a factor.

Most employees who are not eligible for coverage elsewhere look for full medical coverage. For this reason, you are encouraged to study the medical plans comparison chart available from the Benefits Office.

Take the time to review our point-of-service plans (Partners Plus or Partners Value) HMO Blue provider directory, if you haven't done so already. Partners Plus uses a broad network including our own physicians and all our affiliated hospitals. If a point-of-service plan with your primary care physician (PCP) coordinating your care and speciality referrals appeals to you, we encourage you to seriously consider our custom designed product, Partners Plus. Remember: you and your spouse can choose different PCPs if you wish, and you can choose a pediatrician as your children's PCP. It would be possible for a family of four to use four different PCPs.

Then, as with all benefit options, look at your Personal Benefits Summary or rate sheet.

- Choose your coverage level.
- Evaluate the cost for each plan included with your enrollment materials.
- Review your medical plan comparison chart.
- Weigh the level of benefits against the cost.
- Choose a medical plan within 30 days of the date you are first eligible.

Under *Partners Benefits for Residents*, it is intended that all residents will have medical coverage, either through Partners or under another plan available to you. You will not have an opportunity to change this default coverage until the next annual open enrollment period for coverage effective the following January 1.

Therefore, if you do not elect medical coverage within your 30-day election period or indicate that you have alternative coverage, you will automatically be enrolled in Partners Value, for employee only coverage.

Terms to Understand

Copay—The amount you pay per service received, such as office visits, emergency care, prescription drugs, etc. Copays usually range from $10 to $50.

Deductible—The amount you pay before a plan pays any benefits. For example, if you receive out-of-network services under Partners Plus, you would have to pay $200 (for an individual) or a maximum of $400 (for a family) before the plan would pay benefits.

Coinsurance—The plan's share of the charges that are paid after you have met any deductibles. If a plan pays 80%, for example, you would pay the remaining 20%, up to the plan's annual out-of-pocket maximum.

Out-of-Pocket Maximum—The most you would have to pay in deductibles and coinsurance in a calendar year before the plan pays 100% of covered services. Under Partners Value, for example, your out-of-pocket maximum is $2,000 per individual and $4,000 per family when you receive care in-network. After you reach your maximum, including your deductible and copayments, the plan would pay 100% of all remaining covered expenses you incur during the year.

Calendar-Year Maximum—The most a plan will pay in a calendar year for a certain benefit for each covered person.

Highlights of Coverage

Point-of-Service Plans

Partners Plus

In-Network:

- No annual deductible: Plan pays 100% of most covered expenses
- 100% coverage for inpatient services
- $10 copay for office visits and hospital outpatient visits
- $10 copay for routine physicals for adults and children

Out-of-Network:

- $200 annual deductible per individual, $400 per family
- 80% coverage for most services
- Maximum annual employee out-of-pocket cost: $2,000 per individual, $4,000 per family

Partners Value

In-Network:

- $250 annual copay per person for inpatient admissions
- 80% coverage for inpatient services
- $30 copay for office visits and hospital outpatient visits
- $30 copay for routine physicals for adults and children
- Maximum annual employee out-of-pocket cost: $2,000 per individual, $4,000 per family (Excludes annual $250 per person inpatient copayment)

Out-of-Network:

- $500 annual deductible per individual, $1,000 per family
- 70% coverage for most services
- Maximum annual employee out-of-pocket cost: $4,000 per individual, $8,000 per family (Excludes annual $250 per person inpatient copayment)

Indemnity Plan

Master Health Plus

- No annual deductible: Plan pays 100% of most covered expenses
- 100% coverage for inpatient services
- $10 copay for office visits, excluding routine physicals
- $25 copay for hospital outpatient visits

Health Maintenance Organizations

Harvard Pilgrim HealthCare

- No annual deductible
- 100% coverage for inpatient services at affiliated hospitals
- $10 copayment for office visits and outpatient visits

Neighborhood Health Plan

- No annual deductible
- 100% coverage for inpatient services at affiliated hospitals
- $10 copayment for office visits and outpatient visits

Tufts Total Health Plan

- No annual deductible
- 100% coverage for authorized services
- $10 copayment for office visits and outpatient visits

If you enroll in a medical plan, you will receive a separate Merck-Medco identification card for your prescription drug coverage and a kit listing participating pharmacies and non-preferred brand-name drugs.

Prescription Drug Coverage

When you need to fill a prescription, you can go to any pharmacy that participates with the Merck-Medco network and show your pharmacy identification card.

Prescription drug coverage is provided by Merck-Medco based on an open formulary. A formulary is a list of covered prescriptions. The vast majority of therapeutic drugs are included in the formulary. Non-therapeutic drugs, such as those used for cosmetic reasons, are not included.

Co-payments are designed to promote the use of equally-effective, less expensive medications where clinically appropriate. Co-payments are based on the drug's designation in the formulary — generic, preferred, or non-preferred brand-name. This designation is based on the recommendations of the Drug Therapy Committee of the MGH/MGPO and the Pharmacy and Therapeutics Committee of BWH. The existing formulary list is reviewed periodically throughout the year.

	FILLED AT RETAIL PHARMACY (UP TO 30-DAY SUPPLY)	(UP TO 60-DAY SUPPLY)	FILLED ONLINE OR BY MAIL ORDER (90 DAY SUPPLY)
Generic	$ 5	$ 10	$10
Preferred Brand	$10	$ 20	$20
Non-preferred Brand	$25	$ 50	$50

Opt-Out

- Decline medical benefits by indicating your other coverage on your election form
- Apply Choice Pay toward purchase of other benefits, or take as cash

If you are eligible for coverage under another medical plan, consider whether that coverage is adequate and cost-effective. Opting out of medical coverage, provided you are covered elsewhere, could make sense for you.

Selecting Your Primary Care Physician (PCP)

If you enroll in Partners Plus, Partners Value or any of the HMOs, you must select a PCP for yourself and for each family member. If you do not select a PCP, you will not be able to take advantage of your coverage, so it is very important that you complete the PCP selection form for the plan you select.

If you would like help in selecting a primary care physician, help is available. Call the BWH Physician Referral Service for assistance at (617) 732-8288 or the MGH Physician Referral Service at (617) 726-5800.

If you find it more convenient to choose a PCP close to home, you'll find Partners affiliates and PCHI affiliates in many Massachusetts communities: Brigham and Women's Hospital; Faulkner Hospital; Massachusetts General Hospital; Newton-Wellesley Hospital; North Shore Medical Center: North Shore Children's Hospital; Salem Hospital; and Union Hospital.

A special provision of Partners Plus and Partners Value allows your PCP to refer you to BWH or MGH for specialty care, regardless of where your PCP practices, at full benefit levels.

Types of Medical Plans

Partners offers a variety of medical plans from which to choose. Although most people view increased choice as a positive thing, it can also make your decision-making more confusing. This overview should help you better understand your medical plan options.

The spectrum of options includes managed care plans and traditional indemnity plans. The major benefit difference between managed care and indemnity plans is that managed care generally provides more coverage for routine and preventive services.

When choosing your medical plan, consider this: BWH and MGH have satellite locations in many communities. For the most cost-effective access to world-class specialists at BWH and MGH, choose Partners Plus or Partners Value.

With the exception of Partners Value (which has a larger deductible than any of the other options), all plans provide comparable coverage for diagnostic and treatment services, with low out-of-pocket costs. For most people, the level of benefits provided under each plan should not be a major consideration, since most plans offer comparable coverage. If you frequently use certain services, however, you should review the plans carefully for benefits provided for those services or call the Benefits Office for assistance with your decision-making.

An increasingly important factor for you to consider is how and where you receive care, as well as the size and scope of the provider network. Managed care plans put together a network of hospitals, physicians and other health care professionals to provide your care. Under these plans, you select a primary care physician (PCP) to coordinate all health care. All the managed care plans Partners offers maintain large provider networks, and, if you already have a PCP, you may find your doctor in more than one plan. The Partners Plus network includes not only BWH and MGH providers but also the entire HMO Blue network.

Partners Plus and Partners Value

With Partners Plus and Partners Value, you enjoy the benefits of a managed care plan — access to cost-effective, high-quality care — with the freedom of choice of an indemnity plan. For many employees, these programs offer the right combination of coverage, freedom of provider choice and affordability.

Point-of-service (POS) plans such as Partners Plus and Partners Value offer you the best of both HMO and indemnity plan coverage. You may use a POS plan just as you would an HMO, receiving care from network providers under the direction of your PCP. Or, you have the freedom of choice to receive care from a non-network provider, without your PCP's referral, at reduced benefit levels.

Your choice of a PCP generally determines which hospitals and specialists within the network will be available to you, and only your PCP can refer you to other providers if you wish to remain in the network.

After balancing all the factors, many employees have concluded that a point-of-service plan is the choice that best meets their needs.

Spectrum of Choice

Health Maintenance Organizations	*Point-of-Service Plans*	*Indemnity Plans*
Neighborhood Health Plan	Partners Plus	Master Health Plus
Harvard Pilgrim HealthCare	Partners Value	
Tufts Total Health Plan		

Dental

Partners Benefits for Residents offers two dental plans:

- Major Dental
- Basic Dental

Coverage Levels

You have the option of choosing dental coverage in the following categories:

- Employee
- Employee and Children
- Employee and Spouse
- Family

The two plans offer different benefits, so be sure to review each plan carefully. Then select the plan that's best for you.

Determining Your Dental Coverage Needs

It pays to take care of your teeth. Whether or not you need dental coverage depends on several factors; your family's dental history is one of the most important of these.

Your cost for coverage is also a key factor. Look at the benefits available under the two plans. Then, check your Personal Benefits Summary or rate sheet for prices.

To make the right decision, ask yourself these questions:

- What is your own dental history?
- Do you or does a member of your family need special or recurring treatment such as orthodontia or periodontics?
- Do you need coverage for yourself only?
- Do you need coverage for your family?
- Are you covered elsewhere or could you be?
- Do you need only routine check-ups?
- Do you often need fillings and crowns?
- How much did you and other family members spend on dental care last year?

Highlights of Coverage

Before you receive any dental care, be sure that your dentist participates with Delta Dental, so that you receive the highest level of coverage payable under the Plan. Most Massachusetts dentists participate with Delta Dental.

Major Dental

The plan pays 100% of the charges for diagnostic and preventive care, which includes a checkup and cleaning every six months. Then,

- After you pay a $25 annual deductible ($50 per family), the plan will pay:
- 80% of the charges for minor restorative treatment
- 50% of the charges for major restorative treatment
- Maximum benefit: $2,000 per person annually
- Orthodontia benefit (for children only): 50% coverage, no deductible; the plan will pay a lifetime maximum benefit of $2,000 per child under age 19

Basic Dental

The plan pays 100% of the charges for diagnostic and preventive care, which includes a checkup and cleaning every six months. Then,

- After you pay a $50 annual deductible ($100 per family), the plan will pay:
- 50% of the charges for minor restorative treatment
- 50% of the charges for major restorative treatment
- Maximum benefit: $1,000 per person annually

No orthodontia coverage is available under Basic Dental

See the chart on the next page for specific age limitations for certain services.

For more information on dental plan coverage, call 1-800-451-1249.

Dental Services Calendar-Year Maximum	Major Dental $2,000 per person (excluding orthodontia)	Basic Dental $1,000 per person
DIAGNOSTIC/PREVENTIVE SERVICES		
Complete initial exam and charting—once Recall exams every six months X-Rays: full mouth—every 60 months; bitewings—every 12 months for adults, every six months for children under age 19 Single tooth X-Rays as needed Models and casts—every 60 months **Preventive Services** Cleaning, scaling, polishing—every six months Fluoride treatment—every six months for members under age 19 Space maintainers—for members under age 19 Sealants for unrestored permanent molars, once every 48 months for children under age 14	100% COVERAGE NO DEDUCTIBLE	
MINOR RESTORATIVE		
Restorative Services Amalgam (metal) and composite resin (natural color) fillings—once every 12 months per surface, per tooth Temporary fillings—once per tooth Stainless steel crowns (baby teeth only)—once every 24 months per tooth **Oral Surgery** Simple extractions (non-surgical) in dentist's office Surgical extractions (including impactions) in dentist's office All surgery provided in surgical day care or hospital patient must seek benefits from medical insurance) **Periodontics** Periodontal prophylaxis—once every three months following active treatment Scaling of inner gum pockets—once every 24 months Gingivectomy—in dentist's office (If gingivectomy performed in surgical day care or hospital patient must seek benefits from medical insurance) **Endodontics** Root canal therapy—once per tooth Pulpotomy—to age 14 **Prosthetic Maintenance** Denture repairs—once every 12 months, same repair Rebase of dentures—once every 36 months Recementing crowns, inlays and onlays—once every 12 months per tooth **Emergency Dental Care** Palliative treatment—three times in six months **General Anesthesia** (only with covered surgical services)	AFTER A $25 INDIVIDUAL DEDUCTIBLE, $50 FAMILY; 80% COVERAGE	AFTER A $50 INDIVIDUAL DEDUCTIBLE, $100 FAMILY; 50% COVERAGE
MAJOR RESTORATIVE		
Prosthodontics Dentures Fixed bridges and crowns (when part of a bridge)—once every 60 months **Restorative Services** Crowns, inlays, onlays (when teeth cannot be restored with regular fillings)—once every 60 months per tooth	50% COVERAGE AFTER PLAN DEDUCTIBLE	
ORTHODONTIA		
Active orthodontic treatment for children under age 19	50% coverage, no deductible	not available
Lifetime orthodontia maximum	$2,000 per child under age 19	N/A

Vision

Partners Benefits for Residents offers one option:

- Vision Care Plan

Coverage Levels

You have the option of choosing vision care coverage in the following categories:

- Employee
- Employee and Children
- Employee and Spouse
- Family

For most of us, the cost for vision care is a predictable need. The Vision Care Plan provides a way to pay these expenses at a lower cost through a network of optometrists.

Determining Your Vision Care Needs

Vision care is necessary to maintain good health. Periodic vision examinations not only determine the need for corrective eyewear, but also may detect the presence of general health problems in their early stages. With the Vision Care Plan, the costs for these services are low and the benefits great. Ask yourself these questions:

- What are your anticipated vision care expenses for the coming year?
- Would you be willing to use a network of private optometrists for your vision care services?

Highlights of Coverage

To get most value from the Plan, call Davis Vision at 1-800-999-5431 or visit their website at www.davisvision.com for the name of a provider near you. Don't forget that Davis has providers conveniently located near work, at Mass Eye and Ear and Charles River Plaza.

Every 12 months, you may go to a participating provider to receive 100% coverage for:

- An eye examination, after you pay a $10 annual deductible
- One pair of eyeglasses, with plain or tinted lenses
- You can also choose to go out-of-network for reduced benefits

Plan Provision	In-Network Provider	Out-of-Network Provider
EYE EXAMS	100% AFTER YOU PAY $10 ANNUAL DEDUCTIBLE	COVERED UP TO $16
EYEGLASSES OR CONTACT LENSES	ONE PAIR OF EYEGLASSES OR CONTACT LENSES COVERED IN FULL	REIMBURSEMENT LEVELS*
	– EYEGLASS FRAMES FROM DAVIS DESIGNER SELECTION 100%	– FRAMES $14
	VISION LENSES: 100%	ONE PAIR OF LENSES:
	– SINGLE LENSES	– SINGLE LENSES $14
	– BIFOCAL LENSES	– TINTED LENSES $14
	– TRIFOCAL LENSES	– BIFOCAL LENSES $23
	– CONTACT LENSES AFTER YOU PAY 100% $25-$45 FOR STANDARD, SOFT DAILY-WEAR, DISPOSABLE OR PLANNED REPLACEMENT CONTACT LENSES*	– TRIFOCAL LENSES $32
		ONE PAIR OF CONTACT LENSES $45
COVERAGE FREQUENCY	ONCE EVERY 12 MONTHS	ONCE EVERY 12 MONTHS

THE PLAN ALSO COVERS GLASS GRAY #3 PRESCRIPTION LENSES AND PHOTOGRAY EXTRA® PGX (SUN-SENSITIVE) GLASS LENSES.

* YOUR DAVIS PROVIDER WILL GIVE YOU SPECIFIC COPAYMENT INFORMATION FOR THE TYPE OF LENSES YOU REQUIRE OR PREFER.

Long-Term Disability

Partners Benefits for Residents offers two options:

- Long-Term Disability (LTD) Plan — 60% of Pay
- Long-Term Disability (LTD) Plan — 80% of Pay

Coverage Level

- Employee

Determining Your Needs for Long-Term Disability Coverage

If you were disabled and unable to complete your residency or to work for a long period of time:

- How would you pay for food, housing and current monthly bills?
- How would you pay for medical coverage or continue benefits for dental and vision care?
- How would you continue to pay your student loan?

By enrolling for Long-Term Disability coverage, if you become disabled, you will receive a monthly income and your medical, dental, vision and basic life insurance coverage will continue. The plan will also pick up the cost of required student loan payments while you're disabled, subject to a $150,000 maximum.

Most residents cannot afford to be without this excellent coverage.

Highlights of Coverage

- Immediate eligibility, upon completing and returning your benefits enrollment form within the first 30 days of benefits eligibility.
- After being disabled for three months, you'll receive 60% or 80% of your pay with a 3% annual cost-of-living adjustment, if applicable.
- Benefits continue for as long as you remain disabled or until you reach age 65. (If you are age 60 or older when you become disabled, benefits continue for up to five years.)
- If you become disabled during your residency and remain disabled until the time you were scheduled to complete your residency, your benefit is adjusted to reflect 60% of the first year earnings for your specialty.
- Upon completing your residency, you may elect to convert your coverage.

If you elect coverage after the open enrollment period, an evidence of good health form must be approved before coverage can begin.

Life Insurance

Partners offers these programs:

- Employee Basic Life Insurance
- Employee Optional Term Life Insurance and AD&D Insurance
- Spouse Term Life Insurance
- Dependent Term Life Insurance

Coverage Levels

Basic Life

- Employee

Optional Life and AD&D Insurance

- Employee
- Spouse
- Dependent Child(ren) (for Life only)

Determining Your Needs for Optional Life Insurance Coverage

Everyone has different needs for life insurance. For some, the basic benefit is enough. Others need more insurance to help their survivors. To determine how much life insurance you need, ask yourself these questions:

- Does someone besides yourself count on your income?
- Do you have children who will require your assistance to pay for their education?

If the answer to any of these questions is "yes," consider your options to buy additional coverage at very attractive group rates.

Highlights of Coverage

Partners provides you with life insurance:

- Core basic employee life insurance of 1x your annual salary (up to $500,000)

In addition, Partners also offers:

Employee Coverage

- Optional term life insurance
  1x, 2x, 3x, 4x, 5x your annual salary (maximum of $1,000,000) in each program. Newly eligible employees can elect up to 3x salary in optional life insurance, not to exceed $250,000, without providing proof of good health. During open enrollment, you may elect to increase your life insurance coverage by 1x your annual salary if your annual salary is less than or equal to $150,000. If you are electing more than 1x your annual salary or more than $150,000 of coverage you will be required to provide proof of good health.
- Optional AD&D insurance amounting to $100,000

Spouse Coverage

- No proof of good health required if elected within 30 days of initial eligibility or marriage. Otherwise, evidence of insurability will be required.
- Term life insurance amounting to:
  $10,000, $25,000, $50,000, $75,000 or $100,000 in each program
- Optional AD&D insurance amounting to $100,000

Dependent child(ren) Coverage

- No proof of good health required
- Term life insurance $10,000/child no matter how many dependent children you have

Tax Saver Accounts

Partners Benefits for Residents offers two options:

- Health Care Account
- Dependent Care Account

Highlights of Participation

- Health Care Account—Up to $3,000 can be set aside each year to pay for uninsured medical, dental and vision expenses with before-tax dollars.
- Dependent Care Account—Up to $5,000 tax-free per year can be set aside to pay for dependent care.

Tax Saver Accounts let you take advantage of laws that allow you to save on taxes for certain health care and dependent care expenses. There are two separate accounts – one for health care expenses not covered by your medical, dental, or vision plans, and one for dependent care expenses.

For a complete list of eligible expenses, go to the IRS website (http://www.irs.ustreas.gov/prod/forms_pubs/pubs.html) and print off the publications.

Determining Your Needs for Using a Health Care Account

To determine the level of eligible expenses you are likely to incur, review what you have spent on medical care for the last two years and what you expect to spend in the coming months. You should consider how you choose to participate in a particular benefit plan — such as medical, dental or vision care coverage — may affect the amount you might contribute to a Health Care Account. The following examples of eligible expenses may help you determine what types of unreimbursed medical expenses you may claim with your Health Care Account. In general, most health care expenses (medical, dental, vision, hearing, etc.) can be paid through your Health Care Account.

The IRS does not recognize your same-sex domestic partner and his/her children as dependents for tax purposes. As a result, their expenses are not eligible for reimbursement through a Health Care Account.

Examples of Eligible Expenses

Remember: with the range of medical, dental and vision plans available under *Partners Benefits for Residents*, some of these expenses may be partially or fully covered depending upon your personal selections. Any amount covered by your plans and your cost for coverage under *Partners Benefits for Residents* are not eligible expenses.

- *Dental Care* — all uncovered dental care including deductibles, coinsurance and amounts over maximums
- *Vision Care* — all vision aids and exams not covered by a plan; laser vision correction treatment
- *Hearing Care* — exams not covered by a medical plan, hearing aids and batteries
- *Prescription Drugs* — not covered by a medical plan; co-pays
- *Outpatient Psychiatric Care* — in excess of your plan's benefit maximum

- *Health Care* — deductibles, copayments, coinsurance, regular checkups, and other expenses not covered by a plan (as long as they meet the criteria for the federal income tax deduction) including:
  - Prosthetic or orthopedic devices
  - Special medical equipment
  - Psychological or psychiatric care
  - Occupational therapy
  - Prescribed smoking cessation programs
  - Acupuncture
  - Nursing services
  - Other health care expenses such as annual physicals, immunizations and vaccinations

To be reimbursed for your eligible expenses, get a form from the Benefits Office by calling (617) 726-8133, or e-mail Benefits,Information or go to the Partners intranet at http://is.partners.org/hr/

Determining Your Needs for a Dependent Care Account

A Dependent Care Account allows you to set aside tax-free income to pay for dependent care in order for you and your spouse to work.

- An eligible dependent is an individual who is claimed on your tax return as your dependent and who is a child under the age of 13, or a person who is physically or mentally incapable of caring for his or her own needs, regardless of age.
- If you claim the dependent care credit on your tax return or collect compensation through your Dependent Care Account, you must report the name, address and taxpayer identification number of each dependent care provider. If you do not comply, you will either lose the credit or pay taxes on the income placed in your Dependent Care Account.

How Much to Set Aside in Your Dependent Care Account

Before you decide how much to contribute to your Dependent Care Account, it is important to consider:

- Holidays and vacations during which your dependent care needs might change;
- Whether one of your dependents will begin school during the plan year and need less dependent care; and
- Whether any of your dependents will become ineligible for care during the year (for example, by turning age 13).

To qualify, your dependent care expenses can't exceed the earned income, if married, of the lesser-earning spouse.

Tax Credit or Reimbursement Account?

Before enrolling in the Dependent Care Account, you should evaluate whether the tax credit you can take on your federal income tax 1040 form will save you more money than the Dependent Care Account. Which method is best for you will depend on your income, your spouse's income, how much you pay for dependent care, your tax bracket, and the number of dependents you have.

Any expenses reimbursed through a Dependent Care Account cannot be claimed on your federal tax return.

Generally speaking, the lower your income, the more value to you of a tax credit on your annual tax return. A tax deduction, such as that available through the Dependent Care Account, is of more value as your income goes up.

The IRS does not recognize your same-sex domestic partner and his/her children as dependents for tax purposes. As a result, their expenses are not eligible for reimbursement through a Dependent Care Account.

Use It or Lose It

Be sure to estimate your health care and dependent care expenses carefully. Under IRS rules, you must forfeit any unused account balance(s) remaining at year end. Generally, you cannot change or stop contributing during the year unless you have a qualified change of status. You have until March 31st of the subsequent year to submit for reimbursement any expenses you incurred before the end of the previous calendar year.

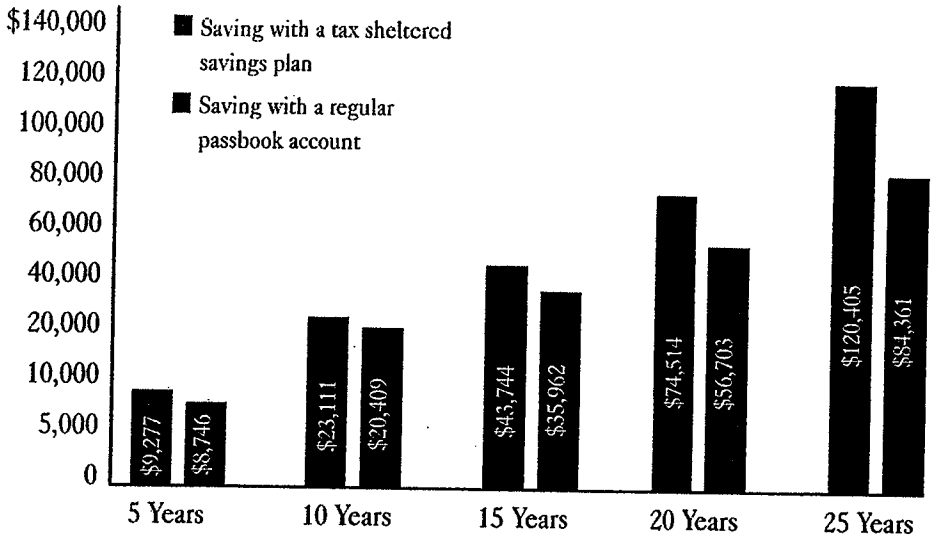
For a more detailed explanation of medical and dependent care reimbursement accounts, refer to IRS publications 502 and 503. You may request a copy from the Benefits Office by using our e-mailbox: Benefits,Information or by calling 617-726-8133 and leaving your request in our forms mailbox. Or, you can go to the IRS website (http://www.irs.ustreas.gov/prod/forms_pubs/pubs.html) and print off a copy.

Tax-Sheltered Annuity Contributions

Experts tell us that to get by comfortably in retirement, we need at least 70% to 80% of the income that we earn the day before we retire. This is known as the income replacement ratio. The Tax-Sheltered Annuity program allows you to set aside up to $11,000 a year on a before-tax basis (subject to other federally-mandated limits). Over the years, your savings can really grow because of the benefits of compounding and tax-deferred savings.

The Power of Tax-Deferred Savings

Consider the advantages of tax-deferred savings over regular after-tax savings. Let's say that this employee saves $29 a week, or $1,508 a year. For this illustration we will assume that she earns an annual return of 8% and is in the 28% tax bracket.



As you can see, over time, your savings can really benefit from the power of tax-deferred savings. A variety of investment options is available ranging from conservative fixed income funds to aggressive stock funds. For more information, call your dedicated service representative.

Why Start Saving Now?

For many people, retirement seems like such a distant goal that they feel no urgency to plan so far ahead. After all, how much can it hurt to wait a few more years?

The chart on the next page shows the real cost of waiting. It compares two 29-year-old co-workers, Dana and Pat. Dana put away $2,000 a year for 10 years (earning a hypothetical 8% rate of return) and then never added another dime to her savings. Pat waited 10 years to start, then invested $2,000 a year until she retired 27 years later at age 65. Dana invested a total of $20,000 while Pat contributed $54,000. Who came out ahead? You might be surprised.

	DANA		PAT	
AGE	INVESTMENT	YEAR-END VALUE*	INVESTMENT	YEAR-END VALUE*
29	$2,000	$ 2,160	0	0
30	2,000	4,493	0	0
31	2,000	7,012	0	0
32	2,000	9,733	0	0
33	2,000	12,672	0	0
34	2,000	15,846	0	0
35	2,000	19,273	0	0
36	2,000	22,975	0	0
37	2,000	26,973	0	0
38	2,000	31,291	0	0
39	0	32,794		
40	0	36,498		
41	0	40,418		
42	0	42,571		
43	0	45,977		
44	0	49,655		
45	0	53,628		
46	0	57,917		
47	0	62,551		
48	0	67,555		
49	0	72,959		
50	0	78,796		
51	0	85,099		
52	0	91,907		
53	0	99,260		
54	0	107,201		
55	0	115,777		
56	0	125,039		
57	0	135,042		
58	0	145,845		
59	0	157,513		
60	0	170,114		
61	0	183,723		
62	0	198,421		
63	0	214,295		
64	0	231,438		
65	0	249,953		
TOTAL AMOUNT INVESTED	$20,000		$54,000	
ACCOUNT VALUE AT AGE 65		$249,953		$188,678

(For illustration purposes only. Your investment experience will differ.)

* Assumes return of 8% per year compounded annually.

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Part 2: Enrollment Information

The amount of Choice Pay available to you is shown on your Personal Benefits Summary at open enrollment or rate sheet, if you are newly eligible for benefits. Your Choice Pay will vary according to the Choice Pay formula (see page 5) and according to your benefit choices. You are encouraged to review this guide, which provides highlights of all available plans.

How the Enrollment Process Works

Enrollment Period

During open enrollment, use the web or telephone enrollment system described on your Personal Benefits Summary. Please refer to your Personal Benefits Summary for specific open enrollment dates.

Newly Eligible Residents

As part of your Resident's orientation you'll receive benefits enrollment materials, including a benefits enrollment form, and have the opportunity to ask questions.

Enrollment Instructions

On the following page you will see a Practice Worksheet. Using your Personal Benefits Summary and rate sheet, you can pencil in pricetags and Choice Pay to consider a variety of scenarios. If you are newly eligible for *Partners Benefits for Residents*, use your rate sheet and benefits enrollment form.

When you have designed the coverage package that best meets your needs, simply enter your choices in the appropriate area of your benefits enrollment form. During the open enrollment period you can enroll online. Send your completed benefits enrollment form to the Benefits Office within 30 days of your eligibility period. **Remember: if we do not receive your response within 30 days of the date your appointment begins, you will be assigned employee-only medical coverage under Partners Value.** You will not have an opportunity to change your coverage until the next annual open enrollment period for coverage effective the following January 1.

Using the Practice Worksheet

If you're interested in testing out choices, you can use the Practice Worksheet.

To make it work for you, line up your rate sheet and benefits enrollment form alongside the worksheet.

- Before enrolling, complete the practice exercise in your guide, where you will enter your choices, the pricetags for your selections and the totals.
- Once you are satisfied with your decisions, it is time to enroll.

NOTE: Your Practice Worksheet and rate sheet are not enrollment forms.

Practice Worksheet

On your Personal Benefits Summary or benefits enrollment form and rate sheet, circle the plans and levels of coverage you want, then enter the pricetags on this worksheet.

Enter basic Choice Pay	$_____
Enter medical participation Choice Pay based on level of coverage you choose (enter 0 if you are not electing Partners medical coverage)	$_____
Enter dental participation Choice Pay based on level of coverage you choose (enter 0 if you are not electing Partners dental coverage)	$_____
Enter Total Choice Pay	**A** $_____

Enter prices for options you choose	Column 1	Column 2
Enter Medical Pricetag	$_____	$_____
Enter Dental Pricetag	$_____	$_____
Enter Vision Pricetag	$_____	$_____
Enter Long-Term Disability Pricetag	$_____	$_____
Enter Employee Optional Life Pricetag	$_____	$_____
Enter Spouse Optional Life Pricetag	$_____	$_____
Enter Child Optional Life Insurance Pricetag	$_____	$_____
Enter Employee AD&D Insurance Pricetag	$_____	$_____
Enter Spouse AD&D Insurance Pricetag	$_____	$_____
Enter Tax Saver Account Amounts:		
Health Care Account Contribution (monthly)	$_____	$_____
Dependent Care Account Contribution (monthly)	$_____	$_____
Add prices for total	**B** $_____	$_____
If B is larger than A	B $_____	B $_____
	-A $_____	-A $_____
	Your Costs $_____	$_____
If A is larger than B	A $_____	A $_____
	-B $_____	-B $_____
	Your Cash $_____	$_____

YOUR COBRA RIGHTS

When you or your covered dependents are no longer eligible for coverage under your medical, dental vision care plan or your health care account, you or your covered dependents may be eligible to continue this coverage as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA).

To continue your coverage (or your dependents' coverage), you will pay up to 102% of the premium cost. This law applies to you if you lose eligibility for coverage due to:

- Termination of employment (for reasons other than gross misconduct);
- Reduction of work hours;
- Divorce or legal separation;
- Your death;
- Your entitlement to Medicare benefits; or
- Loss of status as an eligible dependent.

Contact the Benefits Office at 617-726-8133 if you have any questions about COBRA.

The period of COBRA coverage begins with the date of your qualifying event and continues for up to 18 months from that qualifying event in most cases. If you continue your coverage under COBRA due to divorce or loss of status as an eligible dependent, however, COBRA coverage is available for 36 months. If you are qualified for disability under Title II or Title XVI of the Social Security Act, after you accept COBRA coverage, your COBRA coverage continues for up to 29 months. You will pay up to 150% of the premium cost during the 19th through 29th months.

HOW TO ENROLL FOR COBRA CONTINUATION COVERAGE

To enroll for continuation coverage under COBRA, complete a COBRA election form, which will be mailed to you upon termination from Partners or upon reduction in work hours, or which is available from the Benefits Office. Divorced spouses or individuals who lose status as eligible dependents should call the Benefits Office to leave a message on the coverage continuation mailbox. Return your completed election form to the address on the form within 60 days from your date of termination of coverage or your notification of COBRA eligibility, whichever is later. If you do not return your completed form, Partners will assume that you are waiving continued coverage under COBRA, and you will not be allowed to continue your coverage in the plan. (The 60 days will be counted from the date of the COBRA eligibility notice to the postmarked date of your mailed election form.)

WHEN YOUR COBRA COVERAGE ENDS

Your COBRA coverage will end when:

- You reach the maximum length of time allowed for your COBRA coverage (for example, 18 months or 29 months or 36 months from your qualifying event). (If you are continuing your coverage beyond 18 months due to disability, your coverage will end when you are no longer disabled or after 29 months, whichever is sooner.);
- You fail to make timely payment of your COBRA premiums;
- You enroll in another employer-sponsored health care plan and that plan does not include pre-existing conditions limitations or waiting periods; or
- You become entitled to Medicare benefits.

In addition, your COBRA coverage described in this guide will end when the Hospital terminates its agreement with the health care companies which administer the plans. In this case, your COBRA coverage may continue under another health care plan.

HIPAA PROVISION
If You Declined Medical Coverage Because You Have Coverage Elsewhere

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you may have the opportunity to enroll yourself and your eligible dependents for medical coverage during the year if you previously declined coverage as follows:

- You and/or your dependents have coverage from another source (such as your spouse's medical plan or COBRA coverage) and you lose that coverage, or
- You acquire a dependent through marriage, birth, adoption or placement for adoption.

If you need to enroll for coverage as a result of one of the above events, you must do so within 31 days of the event. Otherwise, you may be required to wait until the next open enrollment period.

PARTNERS™
HEALTHCARE SYSTEM

MASSACHUSETTS GENERAL HOSPITAL AND
BRIGHAM AND WOMEN'S HOSPITAL
ARE FOUNDING MEMBERS OF
PARTNERS HEALTHCARE SYSTEM, INC.

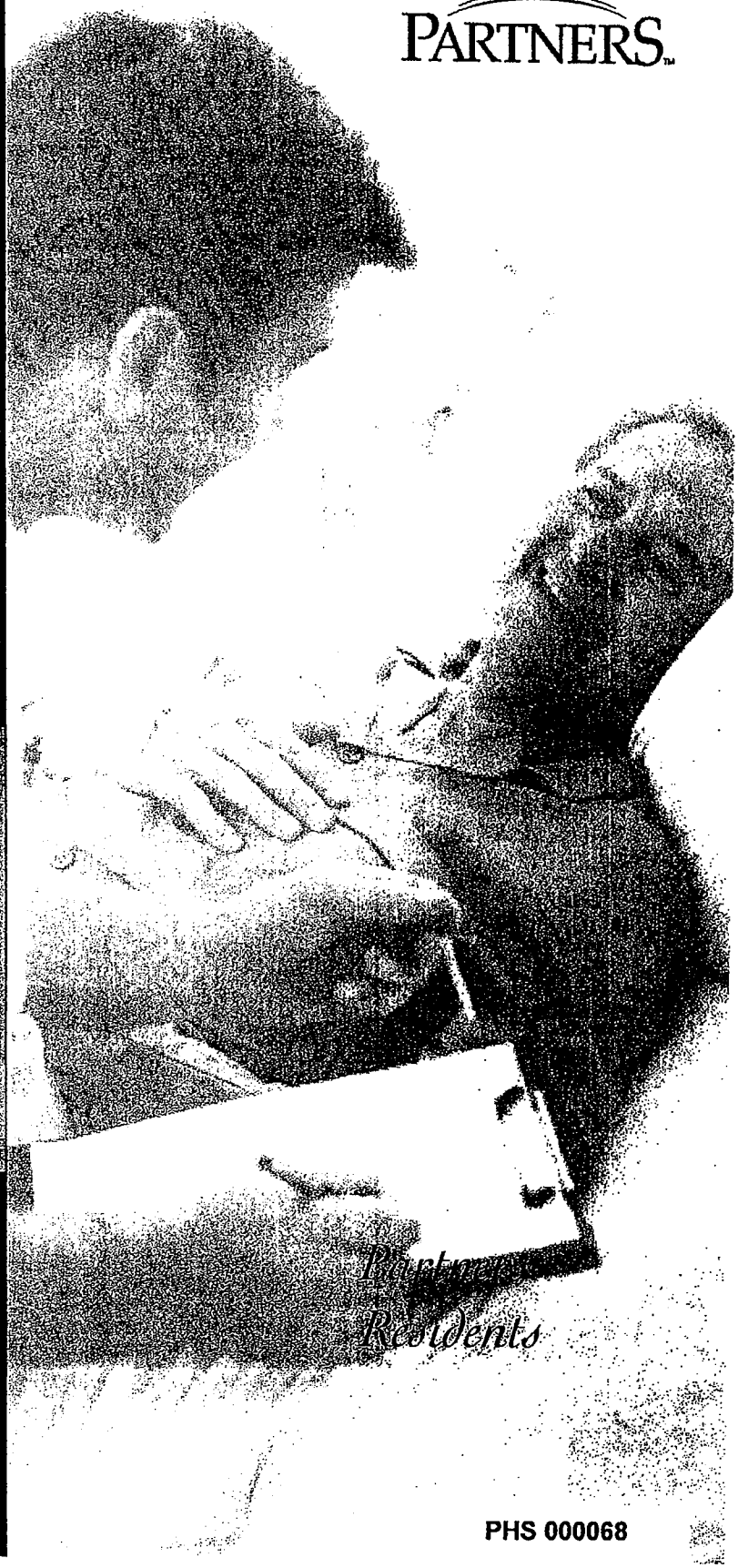
OCTOBER 2001 2,000

EX. 4

2003 Enrollment Guide

PARTNERS

Benefits for Residents



Partners Residents

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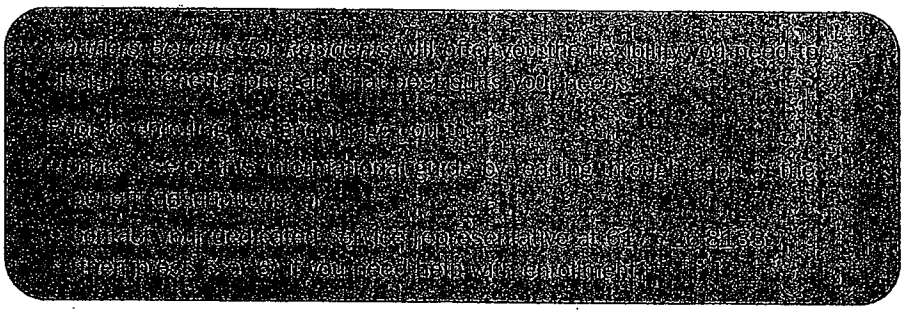
Partners HealthCare System is pleased to offer you

PARTNERS™

Benefits for Residents



The Benefits Office assigns two full-time service representatives to assist our residents and fellows. Your service representatives can be reached by calling 617-726-8133, then pressing 4 for BWH residents or 5 for MGH/SRH residents or fellows, and both are available at the hospital campuses on a regular basis. At BWH, your service representative is available onsite at the Graduate Medical Education Office. Call for the schedule. Our MGH service representative is available at the Professional Staff Benefits Office.

Table of Contents

Part Two

Highlights

Partners Benefits for Residents is designed for your personal benefit. With *Partners Benefits for Residents*, you can select the benefits that will best meet your needs and the needs of your family.

- You will be provided with Choice Pay you can use to purchase the benefits of your choice from the options available.
- You can choose from six medical plans to protect yourself and your family in the event of illness or injury. A prescription drug benefit managed by Medco Health offers you low co-payments and the convenience of a mail service program.
- Two dental plans offer you the level of coverage that is right for your situation.
- A vision care plan offers a cost-effective way for you to get checkups and corrective lenses.
- You can purchase different levels of coverage for medical, dental and vision care (including coverage for your qualifying same-sex domestic partner), tailoring each to best fit your special needs.
- Two Reimbursement Accounts save you tax dollars and reduce your out-of-pocket costs for health care and dependent day care.
- Long-term disability insurance, with unique features for residents, is available for financial protection in the event you cannot work due to an extended illness or injury.
- Basic group life insurance (paid by Partners) in an amount equal to your annual salary will provide protection for your survivors.
- Optional group life insurance allows you to purchase additional life insurance for yourself, your spouse or your dependents.
- Accidental death and dismemberment insurance is available to protect you and your spouse or same-sex domestic partner.

You must make your elections within 30 days of your benefits eligibility date in accordance with IRS regulations that govern the plans. **Coverage is effective on the date you become eligible.**

Information contained in this guide is a summary of the Partners Benefits for Residents Program. If there is a discrepancy between this summary and the plan documents, the plan documents will govern. Plan documents are available in the Benefits Office.

Decisions About Benefit Selections

To use *Partners Benefits for Residents* to your advantage it is necessary to understand the choices you will be making. Take a careful look at this guide, review your Personal Benefits Summary, or your rate sheet, if you are newly eligible for benefits. Use the worksheet on page 29 of this booklet — and keep the following questions in mind.

- Which medical plan is best for my family and me? Could I be covered under another medical plan and use all available Choice Pay to purchase other benefits?
- Should I buy dental coverage for myself and my family? What level of dental coverage should I choose?
- Should I buy vision care for myself and my family?
- Should I buy long-term disability coverage?
- Will I need more life insurance than one times my annual base salary?
- Do I need to buy optional life insurance for my dependents?
- Should I participate in either or both Tax Saver Accounts to pay for certain health care and dependent care expenses?
- Should I begin saving for retirement?

If you are eligible for coverage under another medical plan, you should review that coverage to avoid signing up for a benefit that you may not need. Should that be the case, you could use your Choice Pay toward the purchase of other benefits.

Eligibility

You are eligible for *Partners Benefits for Residents* if you are a resident and you:

- Have an appointment at a sponsoring institution, and
- Are a monthly-paid regular resident scheduled to work at least 87 hours per month at a standard hospital salary of at least $833.33 per month.

Coverage is effective on the date you become eligible.

Dependent Eligibility

Your eligible dependents are your legal spouse or same-sex domestic partner and your dependent unmarried children under age 19. Unmarried children under age 25 who are full-time students are also eligible. For coverage to continue during vacation periods, the child(ren) must be scheduled to enter school the next semester. Your medical and dental plans will request proof of student status at least annually.

Unmarried dependent children of your same-sex domestic partner are also eligible for medical coverage, as long as they otherwise qualify as dependents.

Coverage for Your Same-Sex Domestic Partner

Your same-sex domestic partner may enroll for coverage on the same basis as a spouse. Throughout this guide, any reference to spousal eligibility should also be assumed to include your same-sex domestic partner, unless stated otherwise. Contact the Benefits Office for an informational packet if you are interested in coverage for your same-sex domestic partner and/or the dependent children of your same-sex domestic partner.

To be eligible for same-sex domestic partner coverage, you and your partner must be at least 18 years of age and:

- Not be married to anyone else or be the domestic partner of anyone else;
- Not be related by blood closer than would bar marriage under the law;
- Be jointly responsible for living expenses in a permanent residence that you share;
- Expect your relationship to be permanent; and
- Agree to notify the appropriate parties of any change in the circumstances of your relationship.

Dependent children of qualified same-sex domestic partners are also eligible for coverage on the same basis as step-children. Federal law prohibits you, however, from using either your Dependent Care Account or your Health Care Account to reimburse yourself for expenses incurred by your same-sex domestic partner or his/her children.

Changes After the Enrollment Period

Qualified Change of Status

Open enrollment in *Partners Benefits for Residents* is held annually, usually in late fall. All choices become effective on the first date of the plan year — each January 1. **Newly eligible employees have 30 days to enroll in the** *Partners Benefits for Residents* **program.**

After the enrollment deadline has passed, under IRS regulations you may not add, change or cancel your pre-tax benefit elections until the next plan year, unless you have a qualified change of status.

A qualified change of status occurs if you experience one of the following:

- Marriage or divorce
- Addition of a dependent through birth, adoption or change in custody
- Death of spouse or dependent
- Gain or loss of eligibility for Medicaid, Medicare or other group insurance
- You or your spouse change from benefits-eligible to benefits-ineligible status, or vice versa
- Your spouse's employment ends
- You move out of your HMO's service area
- Gain or loss of full-time student status for dependent age 19 to age 25

The change in coverage you request must be consistent with the change of status that you experience and must be requested within 30 days of the change of status.

Changes to your life insurance elections are allowed after open enrollment. However, adding or increasing life insurance coverage is subject to evidence of good health. Changes or new elections for LTD are allowed at open enrollment and are also subject to evidence of good health.

Part One

Partners Benefits for Residents

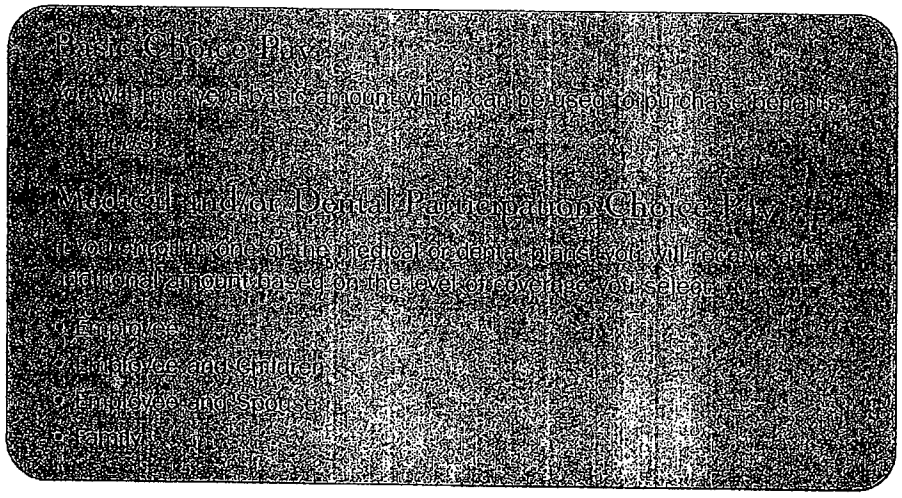
Partners Benefits for Residents is a program that gives you a choice about how Partners dollars are spent on your behalf.

Partners Benefits for Residents is designed to reflect your personal choice by allowing you to select the options that best suit your needs and the needs of your family. Each year during the annual open enrollment period you get an opportunity to reassess your needs and elect your benefits for the following plan year, which begins on January 1.

Choice Pay

Each year Partners gives you Choice Pay, which you can use to purchase benefits that meet your personal needs.

There are three types of Choice Pay available under *Partners Benefits for Residents.*



Choice Pay

Basic Choice Pay

PLUS

Medical Participation Choice Pay

PLUS

Dental Participation Choice Pay

Note: Actual Choice Pay amounts appear on your Personal Benefits Summary or rate sheet.

Partners Benefits for Residents benefit options include:

- Six medical plans
- Two dental plans
- A vision care plan
- A long-term disability plan
- Basic group life insurance coverage
- An optional life insurance plan
- Accidental death and dismemberment coverage
- Two Reimbursement Accounts

If You Have Extra Choice Pay

If you have extra Choice Pay that you do not wish to use for benefits, it can be taken in cash as additional taxable pay (provided you are covered under a medical plan).

If You Choose More Benefits Than You Have Choice Pay

If you choose more benefits than your Choice Pay will cover, you will pay the additional amount through payroll deduction.

Whatever you choose, you'll be the one designing your own benefits program. And choosing your benefits is only one of many *Partners Benefits for Residents* advantages.

The Tax Advantage

Payroll deductions you authorize as payment for many of your benefits can be made with pre-tax dollars, resulting in lower taxes for you.

Pre-Tax Benefits: before federal, state income and Social Security taxes are withheld

- Medical, dental, vision care, Health Care and Dependent Care Accounts and long-term disability (LTD)

Pre-Tax Benefits: before federal and state income taxes are withheld

- Contributions to your voluntary Tax-Sheltered Annuity plan

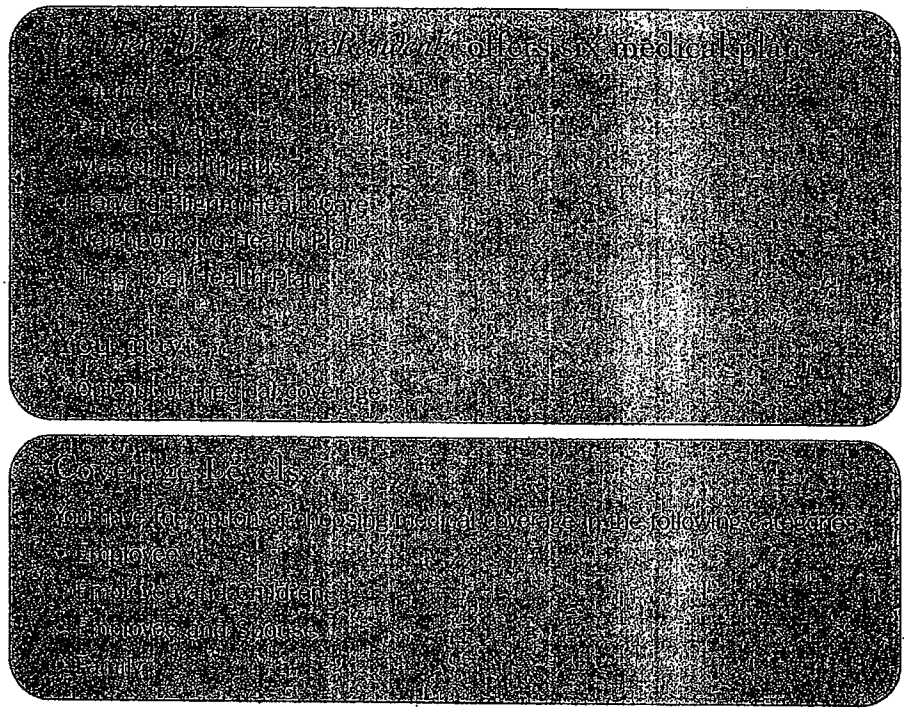
Pre-Tax Benefits: before federal income tax and Social Security tax are withheld

- T-passes (up to certain limits)

After-Tax Benefits: subject to federal and state income and Social Security taxes

- Employee, spouse and dependent optional life insurance
- Accidental death and dismemberment insurance
- Medical, dental or vision coverage for a same-sex domestic partner and his/her dependent children

Medical



Determining Your Medical Coverage Needs

Selecting medical coverage is one of the most important financial decisions you will make in designing your personal *Partners Benefits for Residents* program. For many people, medical coverage is the most highly-valued benefit. But which medical plan is best for you? That depends on many factors.

- What are your anticipated medical expenses for the coming year?
- How much can you pay toward these expenses in deductibles, copayments and coinsurance?
- What is the most you could afford if you or a dependent needed health care?
- Can you opt out of medical coverage because you have coverage elsewhere — for example, through your spouse's employer?
- Is your current doctor on the list of participating physicians in Partners Plus, Partners Value, or one of the HMOs?
- Would you be willing to have your primary care physician direct all of your medical care needs?
- Could you withstand unexpectedly high medical expenses if you were to elect a high out-of-pocket cost option such as Partners Value?

Your cost for coverage is also a factor.

Most employees who are not eligible for coverage elsewhere look for full medical coverage. For this reason, you are encouraged to study the medical plans comparison chart available from the Benefits Office.

Take the time to review our point-of-service plans (Partners Plus or Partners Value) HMO Blue provider directory, if you haven't done so already. Partners Plus uses a broad network including our own physicians and all our affiliated hospitals. If a point-of-service plan with your primary care physician (PCP) coordinating your care and speciality referrals appeals to you, we encourage you to seriously consider our custom designed product, Partners Plus. Remember: you and your spouse can choose different PCPs if you wish, and you can choose a pediatrician as your children's PCP. It would be possible for a family of four to use four different PCPs.

Then, as with all benefit options, look at your Personal Benefits Summary or rate sheet.

- Choose your coverage level.
- Evaluate the cost for each plan included with your enrollment materials.
- Review your medical plan comparison chart.
- Weigh the level of benefits against the cost.
- Choose a medical plan within 30 days of the date you are first eligible.

Under Partners Benefits for Residents, it is intended that all residents will have medical coverage, either through Partners or under another plan available to you. You will not have an opportunity to change this default coverage until the next annual open enrollment period for coverage effective the following January 1.

If you do not elect medical coverage within your 30-day election period or indicate that you have alternative coverage, you will automatically be enrolled in Partners Value, for employee only coverage.

Terms to Understand

Primary Care Physician (PCP) — The doctor you select to provide your medical care and/or refer you to a specialist. Each covered family member may select their own PCP.

Copay — The amount you pay per service received, such as office visits, emergency care, prescription drugs, etc. Copays range from $15 to $50.

Deductible — The amount you pay before a plan pays any benefits. For example, if you receive out-of-network services under Partners Plus, you would have to pay $200 (for an individual) or a maximum of $400 (for a family) before the plan would pay benefits.

Coinsurance — The plan's share of the charges that are paid after you have met any deductibles. If a plan pays 80%, for example, you would pay the remaining 20%, up to the plan's annual out-of-pocket maximum.

Out-of-Pocket Maximum — The most you would have to pay in deductibles and coinsurance in a calendar year before the plan pays 100% of covered services. Under Partners Value, for example, your out-of-pocket maximum is $2,000 per individual and $4,000 per family when you receive care in-network. After you reach your maximum, including your deductible and copayments, the plan would pay 100% of all remaining covered expenses you incur during the year.

Calendar-Year Maximum — The most a plan will pay in a calendar year for a certain benefit for each covered person.

Highlights of Coverage

Point of Service Plans

Partners Plus

In-Network:

- No annual deductible
- Plan pays 100% of most covered expenses
- 100% coverage for inpatient services
- $15 copay for office visits and hospital outpatient visits
- $15 copay for routine physicals for adults and children

Out-of-Network:

- $200 annual deductible per individual, $400 per family
- 80% coverage for most services
- Maximum annual employee out-of-pocket cost: $2,000 per individual, $4,000 per family

Partners Value

In-Network:

- $250 annual copay per person for inpatient admissions
- 80% coverage for inpatient services
- $35 copay for office visits and hospital outpatient visits
- $35 copay for routine physicals for adults and children
- Maximum annual employee out-of-pocket cost: $2,000 per individual, $4,000 per family (Excludes annual $250 per person inpatient copayment)

Out-of-Network:

- $500 annual deductible per individual, $1,000 per family
- 70% coverage for most services
- Maximum annual employee out-of-pocket cost: $4,000 per individual, $8,000 per family (Excludes annual $250 per person inpatient copayment)

Indemnity Plan

Master Health Plus

- No annual deductible
- Plan pays 100% of most covered expenses
- 100% coverage for inpatient services
- $15 copay for office visits, excluding routine physicals
- $30 copay for hospital outpatient visits

Health Maintenance Organizations

Harvard Pilgrim HealthCare

- No annual deductible
- 100% coverage for inpatient services at affiliated hospitals
- $15 copayment for office visits and outpatient visits

Neighborhood Health Plan

- No annual deductible
- 100% coverage for inpatient services at affiliated hospitals
- $15 copayment for office visits and $25 for hospital outpatient visits

Tufts Total Health Plan

- No annual deductible
- 100% coverage for authorized inpatient services
- $15 copayment for office visits and outpatient visits

Prescription Drug Coverage

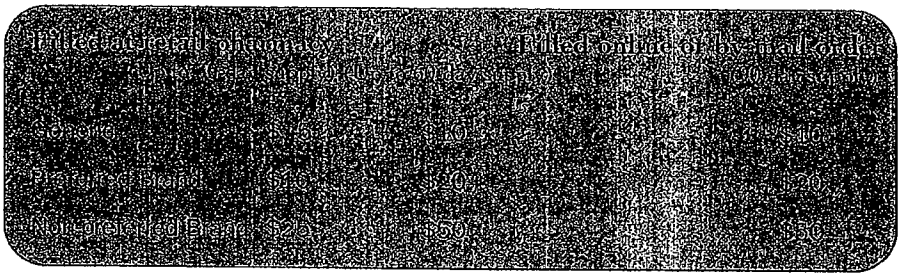
If you enroll in a medical plan, you will receive a separate Medco Health identification card for your prescription drug coverage and a kit listing participating pharmacies and non-preferred brand-name drugs.

When you need to fill a prescription, you can go to any pharmacy that participates with the Medco Health network and show your pharmacy identification card.

Prescription drug coverage is provided by Medco Health based on an open formulary. A formulary is a list of covered prescriptions. The vast majority of therapeutic drugs are included in the formulary. Non-therapeutic drugs, such as those used for cosmetic reasons, are not included.

Co-payments are designed to promote the use of equally-effective, less expensive medications where clinically appropriate. Co-payments are based on the drug's designation in the formulary — generic, preferred, or non-preferred brand-name. This designation is based on the recommendations of the Drug Therapy Committee of the MGH/MGPO and the Pharmacy and Therapeutics Committee of BWH. The existing formulary list is reviewed periodically throughout the year.

Preferred brand name drugs which have a generic equivalent will be covered at the non-preferred brand name copay level — $25.



Opt-Out

- Decline medical benefits by indicating your other coverage on your election form
- Apply Choice Pay toward purchase of other benefits, or take as cash

If you are eligible for coverage under another medical plan, consider whether that coverage is adequate and cost-effective. Opting out of medical coverage, provided you are covered elsewhere, could make sense for you.

Selecting Your Primary Care Physician (PCP)

If you enroll in Partners Plus, Partners Value or any of the HMOs, you must select a PCP for yourself and for each family member. If you do not select a PCP, you will not be able to take advantage of your coverage, so it is very important that you complete the PCP selection form for the plan you select.

If you would like help in selecting a primary care physician, help is available. Call the BWH Physician Referral Service for assistance at 617-732-8288 or the MGH Physician Referral Service at 617-726-5800.

If you find it more convenient to choose a PCP close to home, you'll find Partners affiliates and PCHI affiliates in many Massachusetts communities: Brigham and Women's Hospital; Faulkner Hospital; Massachusetts General Hospital; Newton-Wellesley Hospital; North Shore Medical Center: North Shore Children's Hospital; Salem Hospital; and Union Hospital.

A special provision of Partners Plus and Partners Value allows your PCP to refer you to BWH or MGH for specialty care, regardless of where your PCP practices, at full benefit levels.

Types of Medical Plans

Partners offers a variety of medical plans from which to choose. Although most people view increased choice as a positive thing, it can also make your decision-making more confusing. This overview should help you better understand your medical plan options.

When choosing your medical plan, consider this: BWH and MGH have satellite locations in many communities. For the most cost-effective access to world-class specialists at BWH and MGH, choose Partners Plus or Partners Value.

The spectrum of choice includes several types of managed care plans and traditional indemnity plans. Managed Care plans require that you select a Primary Care Physician to help direct your care, and they place emphasis on preventive services, such as an annual routine physical, to promote good health. Traditional indemnity insurance plans permit self-directed referrals to specialty care but, generally, insure fewer preventive services.

With the exception of Partners Value (which has a larger deductible than any of the other options), all plans provide comparable coverage for diagnostic and treatment services, with low out-of- pocket costs. For most people, the level of benefits provided under each plan should not be a major consideration, since most plans offer comparable coverage. If you frequently use certain services, however, you should review the plans carefully for benefits provided for those services or call the Benefits Office for assistance with your decision-making.

An increasingly important factor for you to consider is how and where you receive care, as well as the size and scope of the provider network. Managed care plans put together a network of hospitals, physicians and other health care professionals to provide your care. Under these plans, you select a primary care physician (PCP) to coordinate all health care. All the managed care plans Partners offers maintain large provider networks, and, if you already have a PCP, you may find your doctor in more than one plan. The Partners Plus network includes not only BWH and MGH participating providers but also the entire HMO Blue network.

Partners Plus and Partners Value

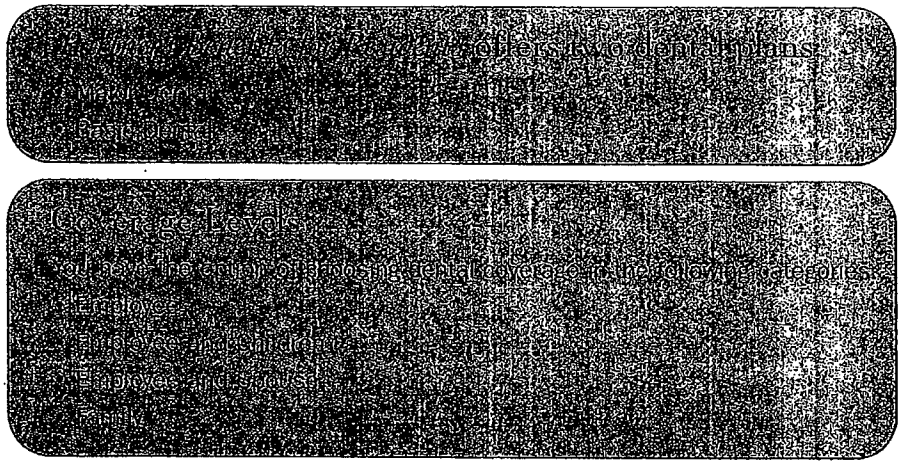
With Partners Plus and Partners Value, you enjoy the benefits of a managed care plan — access to cost-effective, high-quality care — with the freedom of choice of an indemnity plan. For many employees, these programs offer the right combination of coverage, freedom of provider choice and affordability.

Point-of-service (POS) plans such as Partners Plus and Partners Value offer you the best of both HMO and indemnity plan coverage. You may use a POS plan just as you would an HMO, receiving care from network providers under the direction of your PCP. Or, you have the freedom of choice to receive care from a non-network provider, without your PCP's referral, at reduced benefit levels.

Your choice of a PCP generally determines which hospitals and specialists within the network will be available to you, and only your PCP can refer you to other providers if you wish to remain in the network.

After balancing all the factors, many employees have concluded that a point-of-service plan is the choice that best meets their needs.

Dental



The two plans offer different benefits, so be sure to review each plan carefully. Then select the plan that's best for you.

Determining Your Dental Coverage Needs

It pays to take care of your teeth. Whether or not you need dental coverage depends on several factors; your family's dental history is one of the most important of these.

Your cost for coverage is also a key factor. Look at the benefits available under the two plans. Then, check your Personal Benefits Summary or rate sheet for prices.

To make the right decision, ask yourself these questions:

- What is your own dental history?
- Do you or does a member of your family need special or recurring treatment such as orthodontia or periodontics?
- Do you need coverage for yourself only?
- Do you need coverage for your family?
- Are you covered elsewhere or could you be?
- Do you need only routine check-ups?
- Do you often need fillings and crowns?
- How much did you and other family members spend on dental care last year?

Highlights of Coverage

Before you receive any dental care, be sure that your dentist participates with Delta Dental, so that you receive the highest level of coverage payable under the Plan. Most Massachusetts dentists participate with Delta Dental.

Major Dental

The plan pays 100% of the charges for diagnostic and preventive care, which includes a checkup and cleaning every six months. Then,

- After you pay a $25 annual deductible ($50 per family), the plan will pay:
  - 80% of the charges for minor restorative treatment
  - 50% of the charges for major restorative treatment
- Maximum benefit: $2,000 per person annually
- Orthodontia benefit (for children only): 50% coverage, no deductible; the plan will pay a lifetime maximum benefit of $2,000 per child under age 19

Basic Dental

The plan pays 100% of the charges for diagnostic and preventive care, which includes a checkup and cleaning every six months. Then,

- After you pay a $50 annual deductible ($100 per family), the plan will pay:
  - 50% of the charges for minor restorative treatment
  - 50% of the charges for major restorative treatment
- Maximum benefit: $1,000 per person annually

No orthodontia coverage is available under Basic Dental

See the chart on the next page for specific age limitations for certain services.

For more information on dental plan coverage, call 1-800-451-1249.

Dental Services Calendar-Year Maximum	Major Dental $2,000 per person (excluding orthodontia)	Basic Dental $1,000 per person
Diagnostic/Preventive Services		
Complete initial exam and charting — once Recall exams every six months X-Rays: full mouth — every 60 months; bitewings — every 12 months — for adults, every six months for children under age 19 Single tooth X-Rays as needed Models and casts — every 60 months **Preventive Services** Cleaning, scaling, polishing — every six months Fluoride treatment — every six months for members under age 19 Space maintainers — for members under age 19 Sealants for unrestored permanent molars, once every 48 months for children under age 14	100% Coverage No Deductible	
Minor Restorative		
Restorative Services Amalgam (metal) and composite resin (natural color) fillings — once every 12 months per surface, per tooth Temporary fillings — once per tooth Stainless steel crowns (baby teeth only) — once every 24 months per tooth **Oral Surgery** Simple extractions (non-surgical) in dentist's office Surgical extractions (including impactions) in dentist's office — or surgery provided in surgical day care or hospital, patient must seek benefits from medical insurance) **Periodontics** Periodontal prophylaxis — once every three months following active treatment Scaling of inner gum pockets — once every 24 months Gingivectomy — in dentist's office — or gingivectomy performed in surgical day care or hospital, patient must seek benefits from medical insurance) **Endodontics** Root canal therapy — once per tooth Pulpotomy — to age 14 **Prosthetic Maintenance** Denture repairs — once every 12 months, same repair Rebase of dentures — once every 36 months Recementing crowns, inlays and onlays — once every 12 months per tooth **Emergency Dental Care** Palliative treatment — three times in six months **General Anesthesia** (only with covered surgical services)	After a $25 individual deductible, $50 family, 80% Coverage	After a $50 individual deductible, $100 family, 50% Coverage
Major Restorative		
Prosthodontics Dentures Fixed bridges and crowns (when part of a bridge) — once every 60 months **Restorative Services** Crowns, inlays, onlays (when teeth cannot be restored with regular fillings) — once every 60 months per tooth	50% Coverage after plan deductible	
Orthodontia		
Active orthodontic treatment for children under age 19 Lifetime orthodontia maximum	50% coverage, no deductible $2,000 per child under age 19	not available N/A

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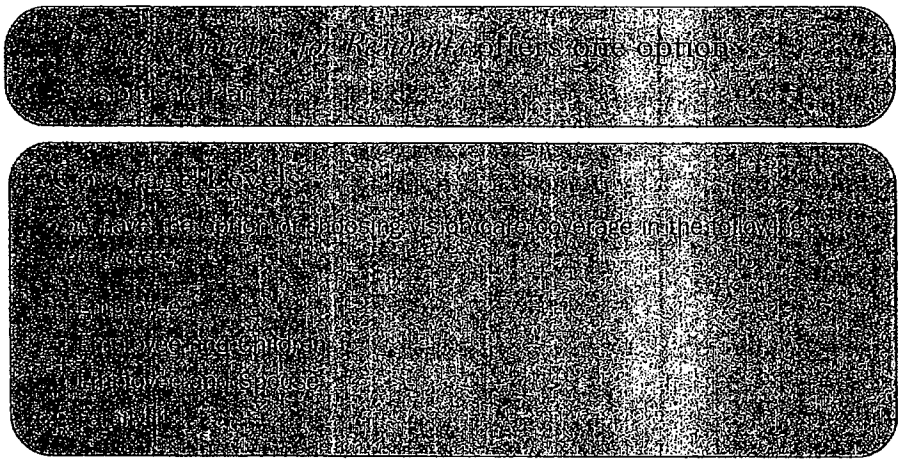
Vision



For most of us, the cost for vision care is a predictable need. The Vision Care Plan provides a way to pay these expenses at a lower cost through a network of optometrists.

Determining Your Vision Care Needs

Vision care is necessary to maintain good health. Periodic vision examinations not only determine the need for corrective eyewear, but also may detect the presence of general health problems in their early stages. With the Vision Care Plan, the costs for these services are low and the benefits great. Ask yourself these questions:

- What are your anticipated vision care expenses for the coming year?
- Would you be willing to use a network of private optometrists for your vision care services?

Highlights of Coverage

To get the most value from the Plan, call Davis Vision at 1-800-999-5431 or visit their website at www.davisvision.com for the name of a provider near you. Don't forget that Davis has providers conveniently located near work, Charles River Plaza and other locations.

Every 12 months, you may go to a participating provider to receive 100% coverage for:

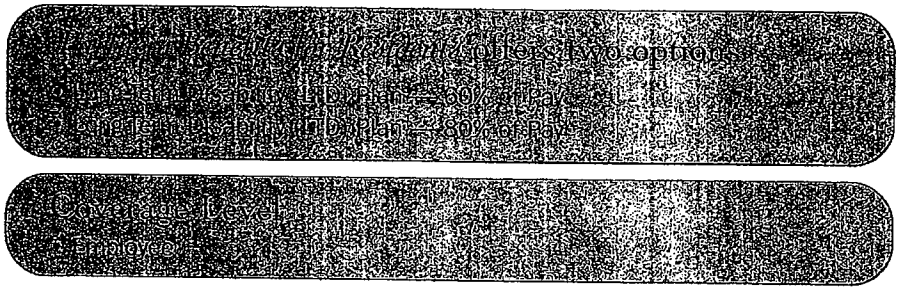
- An eye examination, after you pay a $10 annual deductible
- One pair of eyeglasses, with plain or tinted lenses
- You can also choose to go out-of-network for reduced benefits

Plan Provision	In-Network Provider	Out-of-Network Provider
Eye Exams	100% after you pay $10 annual deductible	Covered up to $16
Eyeglasses or Contact Lenses	One pair of eyeglasses or contact lenses covered in full – Eyeglass frames from Davis Designer selection 100% – Vision lenses 100% – Single lenses – Bifocal lenses – Trifocal lenses – Contact lenses after you pay $25 $45 for standard, soft daily wear, disposable or planned replacement contact lenses* 100%	Reimbursement levels: – Frames up to $14 One pair of lenses: – Single lenses $14 – Tinted Lenses $14 – Bifocal lenses $23 – Trifocal lenses $32 One pair of contact lenses $45
Coverage frequency	Once every 12 months	Once every 12 months

The plan also covers glass gray #3 prescription lenses and photogray Extra® PGX (sun-sensitive) glass lenses.

* Your Davis provider will give you specific copayment information for the type of lenses you require or prefer.

Long-Term Disability



Determining Your Needs for Long-Term Disability Coverage

If you were disabled and unable to complete your residency or to work for a long period of time:

- How would you pay for food, housing and current monthly bills?
- How would you pay for medical coverage or continue benefits for dental and vision care?
- How would you continue to pay your student loan?

By enrolling for Long-Term Disability coverage, if you become disabled, you will receive a monthly income and your medical, dental, vision and basic life insurance coverage will continue. The plan will also pick up the cost of required student loan payments while you're disabled, subject to a $150,000 maximum.

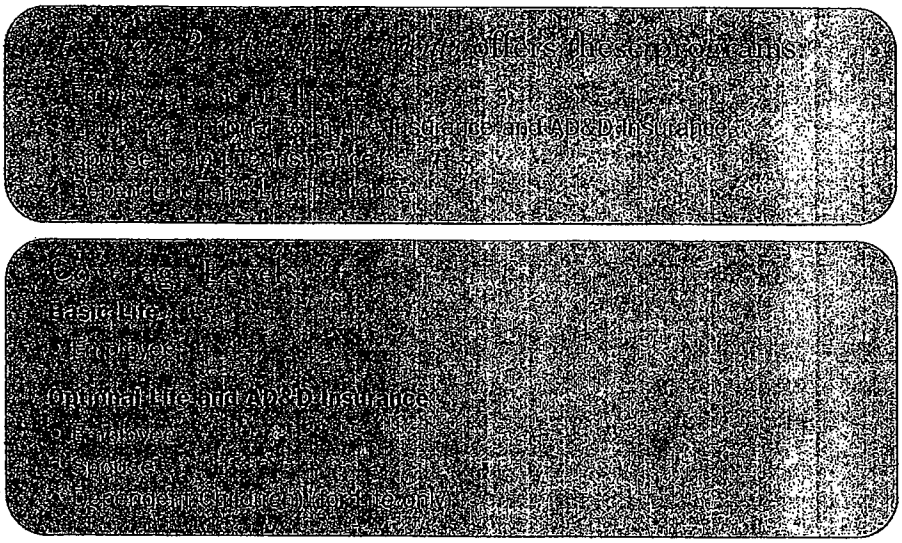
Most residents cannot afford to be without this excellent coverage.

Highlights of Coverage

- Immediate eligibility, upon completing and returning your benefits enrollment form within the first 30 days of benefits eligibility.
- After being disabled for three months, you'll receive 60% or 80% of your pay with a 3% annual cost-of-living adjustment, if applicable.
- Benefits continue for as long as you remain disabled or until you reach age 65. (If you are age 60 or older when you become disabled, benefits continue for up to five years.)
- If you become disabled during your residency and remain disabled until the time you were scheduled to complete your residency, your benefit is adjusted to reflect 60% of the first year earnings for your specialty.
- Upon completing your residency, you may elect to convert your coverage.

If you elect coverage after the open enrollment period, an evidence of good health form must be approved before coverage can begin.

Life Insurance



Determining Your Needs for Optional Life Insurance Coverage

Everyone has different needs for life insurance. For some, the basic benefit is enough. Others need more insurance to help their survivors. To determine how much life insurance you need, ask yourself these questions:

- Does someone besides yourself count on your income?
- Do you have children who will require your assistance to pay for their education?

If the answer to any of these questions is "yes," consider your options to buy additional coverage at very attractive group rates.

Highlights of Coverage

Partners provides you with life insurance:

- Core basic employee life insurance of 1x your annual base salary (up to $500,000)

In addition, Partners also offers:

Employee Coverage

- Optional term life insurance
  1x, 2x, 3x, 4x, 5x your annual base salary (maximum of $1,000,000). Newly eligible employees can elect up to 3x salary in optional life insurance, not to exceed $250,000, without providing proof of good health. During open enrollment, you may elect to increase your life insurance coverage by 1x your annual base salary if your annual base salary is less than or equal to $150,000. If you are electing more than 1x your annual base salary or more than $150,000 of coverage you will be required to provide proof of good health.
- Optional AD&D insurance amounting to $100,000

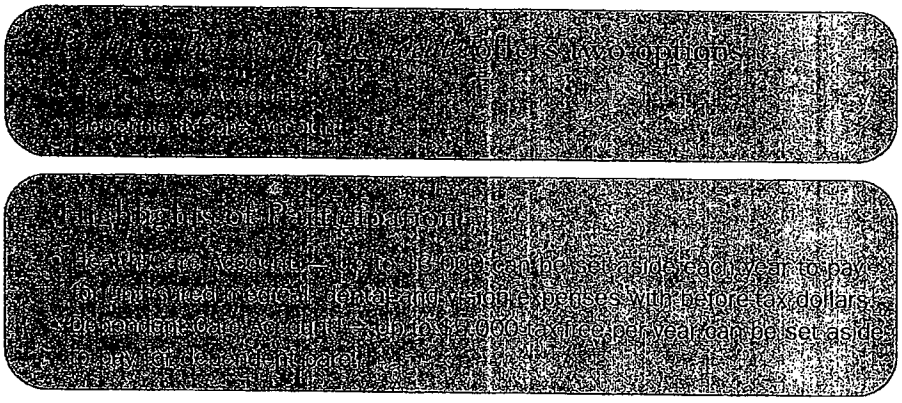
Spouse Coverage

- No proof of good health required if elected within 30 days of initial eligibility or marriage. Otherwise, evidence of insurability will be required.
- Term life insurance amounting to:
  $10,000, $25,000, $50,000, $75,000 or $100,000 in each program
- Optional AD&D insurance amounting to $100,000

Dependent child(ren) Coverage

- No proof of good health required
- Term life insurance $10,000/child no matter how many dependent children you have
- When dependent children are no longer eligible* no benefits are payable, even if premiums are still being deducted from your paycheck. You must contact the Benefits Office when your dependents are no longer eligible (such as when they reach age 19, or are no longer students).

Reimbursement Accounts



Reimbursement Accounts let you take advantage of laws that allow you to save on taxes for certain health care and dependent care expenses. There are two separate accounts — one for health care expenses not covered by your medical, dental, or vision plans, and one for dependent care expenses.

Determining Your Needs for Using a Health Care Account

To determine the level of eligible expenses you are likely to incur, review what you have spent on medical care for the last two years and what you expect to spend in the coming months. You should consider how you choose to participate in a particular benefit plan — such as medical, dental or vision care coverage — may affect the amount you might contribute to a Health Care Account. The following examples of eligible expenses may help you determine what types of unreimbursed medical expenses you may claim with your Health Care Account. In general, most health care expenses (medical, dental, vision, hearing, etc.) can be paid through your Health Care Account.

The IRS does not recognize your same-sex domestic partner and his/her children as dependents for tax purposes. As a result, their expenses are not eligible for reimbursement through a Health Care Account.

Examples of Eligible Expenses

Remember: with the range of medical, dental and vision plans available under *Partners Benefits for Residents*, some of these expenses may be partially or fully covered depending upon your personal selections. Any amount covered by your plans and your cost for coverage under *Partners Benefits for Residents* are not eligible expenses.

- **Dental Care** — all uncovered dental care including deductibles, coinsurance and amounts over maximums
- **Vision Care** — all vision aids and exams not covered by a plan; laser vision correction treatment
- **Hearing Care** — exams not covered by a medical plan, hearing aids and batteries
- **Prescription Drugs** — not covered by a medical plan; co-pays
- **Outpatient Psychiatric Care** — in excess of your plan's benefit maximum

For a complete list of eligible expenses, go to the IRS website (http://www.irs.ustreas.gov/prod/forms_pubs/pubs.html) and print off the publications.

- **Health Care** — deductibles, copayments, coinsurance, regular checkups, and other expenses not covered by a plan (as long as they meet the criteria for the federal income tax deduction) including:
  - Prosthetic or orthopedic devices
  - Special medical equipment
  - Psychological or psychiatric care
  - Occupational therapy
  - Prescribed smoking cessation programs
  - Acupuncture
  - Nursing services
  - Other health care expenses such as annual physicals, immunizations and vaccinations

To be reimbursed for your eligible expenses, get a form from the Benefits Office by calling 617-726-8133, or e-mail Benefits,Information or go to the Partners intranet at http://is.partners.org/hr/

Determining Your Needs for a Dependent Care Account

A Dependent Care Account allows you to set aside tax-free income to pay for dependent care in order for you and your spouse to work.

- An eligible dependent is an individual who is claimed on your tax return as your dependent and who is a child under the age of 13, or a person who is physically or mentally incapable of caring for his or her own needs, regardless of age.
- If you claim the dependent care credit on your tax return or collect compensation through your Dependent Care Account, you must report the name, address and taxpayer identification number of each dependent care provider. If you do not comply, you will either lose the credit or pay taxes on the income placed in your Dependent Care Account.

How Much to Set Aside in Your Dependent Care Account

Before you decide how much to contribute to your Dependent Care Account, it is important to consider:

- Holidays and vacations during which your dependent care needs might change;
- Whether one of your dependents will begin school during the plan year and need less dependent care; and
- Whether any of your dependents will become ineligible for care during the year (for example, by turning age 13).

To qualify, your dependent care expenses can't exceed the earned income, if married, of the lesser-earning spouse.

Tax Credit or Reimbursement Account?

Before enrolling in the Dependent Care Account, you should evaluate whether the tax credit you can take on your federal income tax 1040 form will save you more money than the Dependent Care Account. Which method is best for you will depend on your income, your spouse's income, how much you pay for dependent care, your tax bracket, and the number of dependents you have.

Any expenses reimbursed through a Dependent Care Account cannot be claimed on your federal tax return.

Generally speaking, the lower your income, the more value to you of a tax credit on your annual tax return. A tax deduction, such as that available through the Dependent Care Account, is of more value as your income goes up.

The IRS does not recognize your same-sex domestic partner and his/her children as dependents for tax purposes. As a result, their expenses are not eligible for reimbursement through a Dependent Care Account.

Use It or Lose It — Health Care and Dependent Care Accounts

Be sure to estimate your health care and dependent care expenses carefully. Under IRS rules, you must forfeit any unused account balance(s) remaining at year end. Generally, you cannot change or stop contributing during the year unless you have a qualified change of status. You have until March 31st of the subsequent year to submit for reimbursement any expenses you incurred before the end of the previous calendar year.

For a more detailed explanation of medical and dependent care reimbursement accounts, refer to IRS publications 502 and 503. You may request a copy from the Benefits Office by using our e-mailbox: Benefits,Information or by calling 617-726-8133 and leaving your request in our forms mailbox. Or, you can go to the IRS website (http://www.irs.ustreas.gov/prod/forms_pubs/pubs.html) and print off a copy.

Annuity Contributions

Tax Sheltered

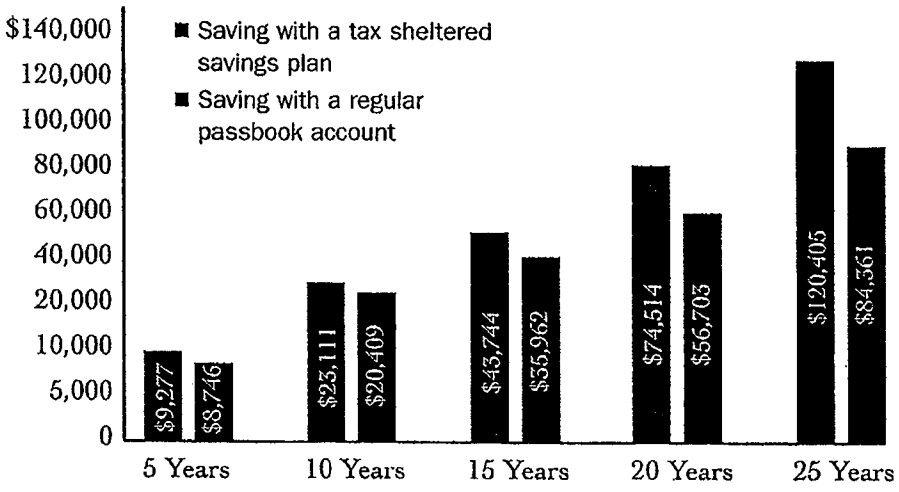
As you can see, over time, your savings can really benefit from the power of tax-deferred savings. A variety of investment options is available ranging from conservative fixed income funds to aggressive stock funds. For more information, call your dedicated service representative.

Experts tell us that to get by comfortably in retirement, we need at least 70% to 80% of the income that we earn the day before we retire. This is known as the income replacement ratio. The Tax-Sheltered Annuity program allows you to set aside up to $12,000* a year in 2003 on a before-tax basis (subject to other federally-mandated limits). Over the years, your savings can really grow because of the benefits of compounding and tax-deferred savings.

* $12,000 will increase by $1,000 per year through 2006.

The Power of Tax-Deferred Savings

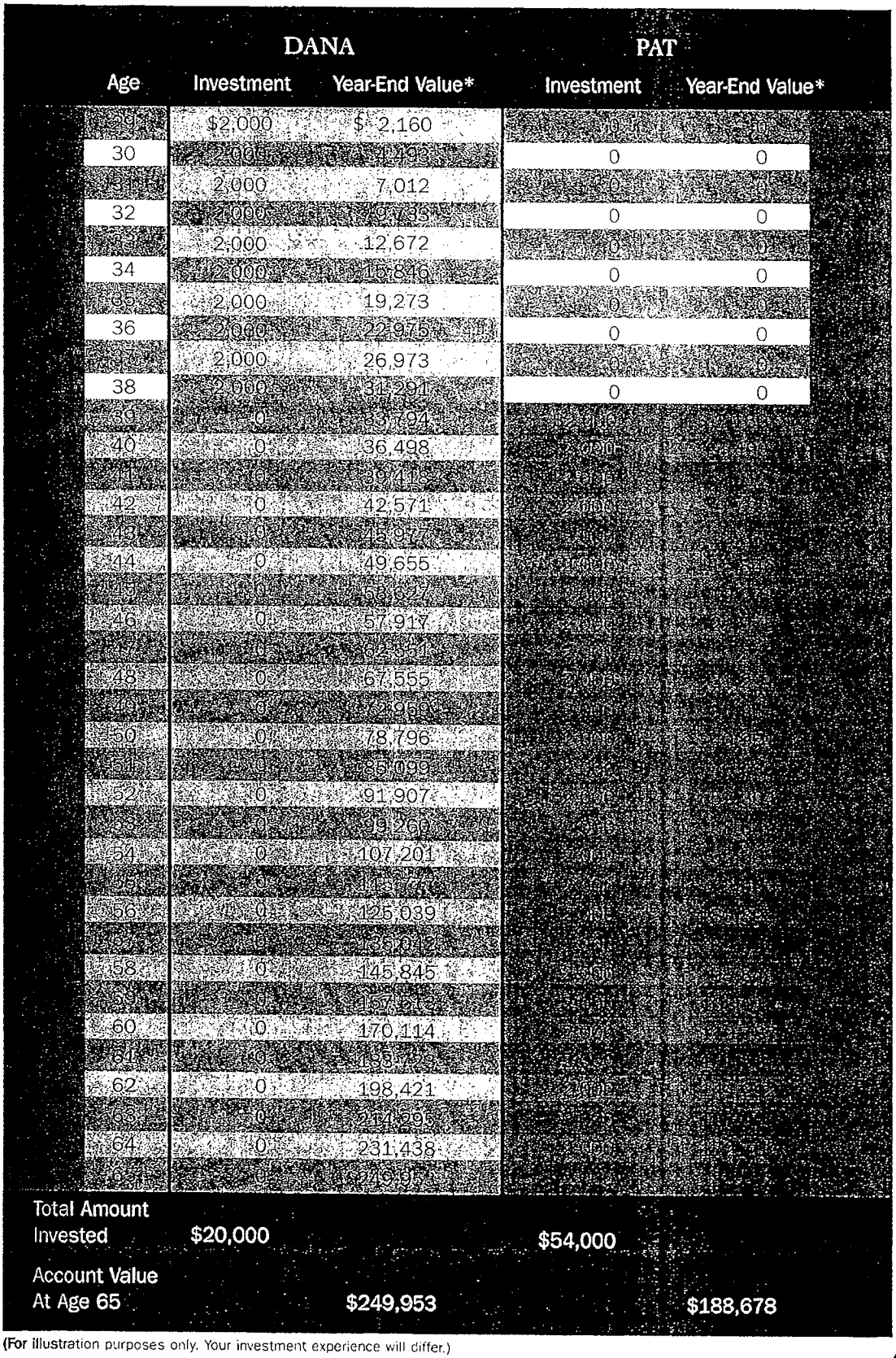
Consider the advantages of tax-deferred savings over regular after-tax savings. Let's say that this employee saves $29 a week, or $1,508 a year. For this illustration we will assume that she earns an annual return of 8% and is in the 28% tax bracket.



Why Start Saving Now?

For many people, retirement seems like such a distant goal that they feel no urgency to plan so far ahead. After all, how much can it hurt to wait a few more years?

The chart on the next page shows the real cost of waiting. It compares two 29-year-old co-workers, Dana and Pat. Dana put away $2,000 a year for 10 years (earning a hypothetical 8% rate of return) *and then never added another dime to her savings.* Pat waited 10 years to start, then invested $2,000 a year until she retired 27 years later at age 65. *Dana invested a total of $20,000 while Pat contributed $54,000.* Who came out ahead? You might be surprised.



Age	DANA Investment	DANA Year-End Value*	PAT Investment	PAT Year-End Value*
29	$2,000	$ 2,160		
30	2,000	4,493	0	0
31	2,000	7,012	0	0
32	2,000	9,733	0	0
33	2,000	12,672	0	0
34	2,000	15,846	0	0
35	2,000	19,273	0	0
36	2,000	22,975	0	0
37	2,000	26,973	0	0
38	2,000	31,291	0	0
39	0	33,794		
40	0	36,498		
41	0	39,418		
42	0	42,571		
43	0	45,977		
44	0	49,655		
45	0	53,627		
46	0	57,917		
47	0	62,551		
48	0	67,555		
49	0	72,960		
50	0	78,796		
51	0	85,099		
52	0	91,907		
53	0	99,260		
54	0	107,201		
55	0	115,777		
56	0	125,039		
57	0	135,042		
58	0	145,845		
59	0	157,513		
60	0	170,114		
61	0	183,723		
62	0	198,421		
63	0	214,295		
64	0	231,438		
65	0	249,953	0	188,678
Total Amount Invested	$20,000		$54,000	
Account Value At Age 65		$249,953		$188,678

(For illustration purposes only. Your investment experience will differ.)

* Assumes return of 8% per year compounded annually.

Part Two

Enrollment Information

The amount of Choice Pay available to you is shown on your Personal Benefits Summary at open enrollment or rate sheet, if you are newly eligible for benefits. Your Choice Pay will vary according to the Choice Pay formula (see page 5) and according to your benefit choices. You are encouraged to review this guide, which provides highlights of all available plans.

How the Enrollment Process Works

Enrollment Period

During open enrollment, use the web or telephone enrollment system described on your Personal Benefits Summary. Please refer to your Personal Benefits Summary for specific open enrollment dates.

Newly Eligible Residents

As part of your Resident's orientation you'll receive benefits enrollment materials, including a benefits enrollment form, and have the opportunity to ask questions.

Enrollment Instructions

On the following page you will see a Practice Worksheet. Using your Personal Benefits Summary and rate sheet, you can pencil in pricetags and Choice Pay to consider a variety of scenarios. If you are newly eligible for *Partners Benefits for Residents*, use your rate sheet and benefits enrollment form.

When you have designed the coverage package that best meets your needs, simply enter your choices in the appropriate area of your benefits enrollment form. During the open enrollment period you can enroll online. Send your completed benefits enrollment form to the Benefits Office within 30 days of your eligibility period. **Remember: if we do not receive your response within 30 days of the date your appointment begins, you will be assigned employee-only medical coverage under Partners Value.** You will not have an opportunity to change your coverage until the next annual open enrollment period for coverage effective the following January 1.

Using the Practice Worksheet

If you're interested in testing out choices, you can use the Practice Worksheet.

[illegible] your rate sheet and benefits enrollment [illegible] Worksheet.

Before enrolling, complete the practice exercise in your guide, where you will enter your choices, the pricetags for your selections and the totals.

Once you are satisfied with your decisions, it is time to enroll.

NOTE: Your Practice Worksheet and rate sheet are not enrollment forms.

PHS 000099

Practice Worksheet

On your Personal Benefits Summary or benefits enrollment form and rate sheet, circle the plans and levels of coverage you want, then enter the pricetags on this worksheet.

Enter basic Choice Pay		$_____
Enter medical participation Choice Pay based on level of coverage you choose (enter 0 if you are not electing Partners medical coverage)		$_____
Enter dental participation Choice Pay based on level of coverage you choose (enter 0 if you are not electing Partners dental coverage)		$_____
Enter Total Choice Pay	**A**	$_____

Enter prices for options you choose		Column 1	Column 2
Enter Medical Pricetag		$_____	$_____
Enter Dental Pricetag		$_____	$_____
Enter Vision Pricetag		$_____	$_____
Enter Long-Term Disability Pricetag		$_____	$_____
Enter Employee Optional Life Pricetag		$_____	$_____
Enter Spouse Optional Life Pricetag		$_____	$_____
Enter Child Optional Life Pricetag		$_____	$_____
Enter Employee AD&D Insurance Pricetag		$_____	$_____
Enter Spouse AD&D Insurance Pricetag		$_____	$_____
Enter Reimbursement Account Amounts:			
Health Care Account Contribution (monthly)		$_____	$_____
Dependent Care Account Contribution (monthly)		$_____	$_____
Add prices for total	**B**	$_____	$_____
If B is larger than A	B	$_____	B $_____
	-A	$_____	-A $_____
	Your Costs	$_____	$_____
If A is larger than B	A	$_____	A $_____
	-B	$_____	-B $_____
	Your Cash	$_____	$_____

Your COBRA Rights

When you or your covered dependents are no longer eligible for coverage under your medical, dental vision care plan or your health care account, you or your covered dependents may be eligible to continue this coverage as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA).

To continue your coverage (or your dependents' coverage), you will pay up to 102% of the premium cost. This law applies to you if you lose eligibility for coverage due to:

- Termination of employment (for reasons other than gross misconduct);
- Reduction of work hours;
- Divorce or legal separation;
- Your death;
- Your entitlement to Medicare benefits; or
- Loss of status as an eligible dependent.

Contact the Benefits Office at 617-726-8133 if you have any questions about COBRA.

The period of COBRA coverage begins with the date of your qualifying event and continues for up to 18 months from that qualifying event in most cases. If you continue your coverage under COBRA due to divorce or loss of status as an eligible dependent, however, COBRA coverage is available for 36 months. If you are qualified for disability under Title II or Title XVI of the Social Security Act, after you accept COBRA coverage, your COBRA coverage continues for up to 29 months. You will pay up to 150% of the premium cost during the 19th through 29th months.

How to Enroll for COBRA Continuation Coverage

To enroll for continuation coverage under COBRA, complete a COBRA election form, which will be mailed to you upon termination from Partners or upon reduction in work hours, or which is available from the Benefits Office. Divorced spouses or individuals who lose status as eligible dependents should call the Benefits Office to leave a message on the coverage continuation mailbox. Return your completed election form to the address on the form within 60 days from your date of termination of coverage or your notification of COBRA eligibility, whichever is later. If you do not return your completed form, Partners will assume that you are waiving continued coverage under COBRA, and you will not be allowed to continue your coverage in the plan. (The 60 days will be counted from the date of the COBRA eligibility notice to the postmarked date of your mailed election form.)

When Your COBRA Coverage Ends

Your COBRA coverage will end when:

- You reach the maximum length of time allowed for your COBRA coverage (for example, 18 months or 29 months or 36 months from your qualifying event). (If you are continuing your coverage beyond 18 months due to disability, your coverage will end when you are no longer disabled or after 29 months, whichever is sooner.);
- You fail to make timely payment of your COBRA premiums;
- You enroll in another employer-sponsored health care plan and that plan does not include pre-existing conditions limitations or waiting periods; or
- You become entitled to Medicare benefits.

In addition, your COBRA coverage described in this guide will end when the Hospital terminates its agreement with the health care companies which administer the plans. In this case, your COBRA coverage may continue under another health care plan.

HIPAA Provision (Health Insurance Portability and Accountability Act of 1996)

If You Declined Medical Coverage Because You Have Coverage Elsewhere

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you may have the opportunity to enroll yourself and your eligible dependents for medical coverage during the year if you previously declined coverage as follows:

- You and/or your dependents have coverage from another source (such as your spouse's medical plan or COBRA coverage) and you lose that coverage, or
- You acquire a dependent through marriage, birth, adoption or placement for adoption.

If you need to enroll for coverage as a result of one of the above events, you must do so within 31 days of the event. Otherwise, you may be required to wait until the next open enrollment period.

Benefits Enrollment Guide

PARTNERS HEALTHCARE SYSTEM

Massachusetts General Hospital and Brigham and Women's Hospital are founding members of Partners HealthCare System, Inc.

October 2002 2,000

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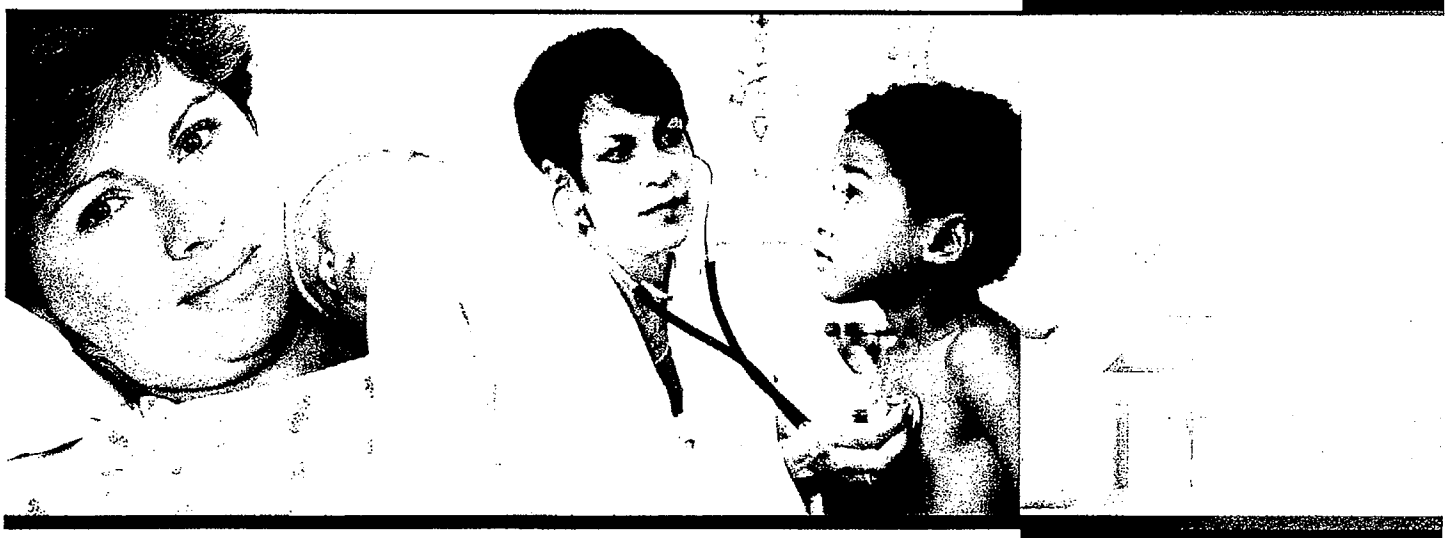
EX. 5

Benefits Enrollment Guide



PARTNERS HEALTHCARE SYSTEM

October 2002 4,000

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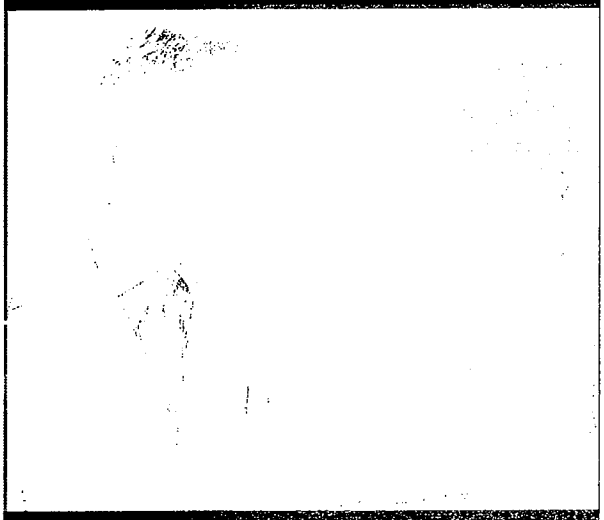
2003 Enrollment Guide

MASSACHUSETTS GENERAL HOSPITAL



Professional Staff Benefits Program

PARTNERS HealthCare System Member

Massachusetts General Physicians Organization

Massachusetts General Physicians Organization

PHS 003227

Table of Contents

Highlights

The Professional Staff Benefits Program is designed with the advice and counsel of members of the MGH Professional Staff to meet the interests and needs of their members and families.

Featured are:

- A broad spectrum of **Medical Insurance** plans from traditional indemnity plans to HMO's will help pay for health care needs.
- Two **Dental Insurance** plans offer differing levels of insurance support for dental services from regular preventive care to orthodontia.
- A **Vision Care** plan provides cost-effective coverage of eye examinations and corrective lenses.
- Wherever possible, we take advantage of relevant sections of the Internal Revenue Code which allow for **tax-favored treatment of employee contributions.**
- A **Health Care Reimbursement Account** permits participants to set aside funds to pay for most uninsured health care expenses with cash that is not taxed by the federal and state governments.
- **Long-Term Disability Insurance** will provide financial protection in the event one cannot work due to accident or illness.
- **Basic Group Term Life Insurance** equal to annual salary forms the beginning of a survivor protection plan.
- **Supplemental Group Term Life Insurance** in multiples of up to 5 times annual salary continues to build a survivor protection plan.
- **Spouse and Child Group Term Life Insurance** may be added to protect overall family interests.
- **Accidental Death and Dismemberment Insurance (AD&D)** for both participant and spouse completes the survivor protection plan.
- **MGH Academic Annuity Plan (AAP)** participants receive pension plan contributions from the MGH/MGPO. The AAP is a defined contribution pension plan that permits participate-directed investment opportunities of retirement plan assets.
- A **Tax Sheltered Annuity Program** permits voluntary tax deferred saving to supplement pension plan savings.
- **Malpractice Insurance** provides best quality professional and general liability insurance to all eligible members of the Professional Staff.
- The **"Work and Family"** program completes the benefits package with paid **Maternity and Adoption Leave Programs,** on-site child care facilities and a **"Tax-Saver" Dependent Care Reimbursement Plan** that may significantly reduce the cost of child care.
- Discounted membership to the **MGH/Charles River Park Fitness Center** is available to the Professional Staff.
- For more information see our web-site at **www.mgh.harvard.edu/physicianbenefits/**

Eligibility

To participate in the MGH/MGPO Professional Staff Benefits Program you must have:

- A Professional Staff appointment at Massachusetts General Hospital; and
- Be actively employed at MGH, with a regular annual salary of at least $10,000, (at least $834 per month).

Selecting Your Coverage Levels

When you enroll for medical, dental and vision care coverage, you may enroll in different coverage levels for each benefit. For example, you could enroll in Family coverage for medical, and Employee coverage for dental.

Your options include:

- Employee (yourself only)
- Family (yourself, your spouse or same-sex domestic partner, and your eligible dependents) (See "Eligible Dependents" below)

Eligible same-sex domestic partners may enroll for coverage on the same basis as a spouse. Please see the information provided below if you are interested in coverage for a same-sex domestic partner and/or children of a same-sex domestic partner.

Eligible Dependents

You may enroll your dependents for medical, dental, vision and life insurance coverage if they are in one of the following categories:

- Your legal spouse or eligible same-sex domestic partner;
- Unmarried children under age 19;
- Unmarried children from age 19 until they reach age 25, as long as they are full-time students. Proof of full-time student status is required;
- Children who are mentally or physically handicapped and incapable of self-support, even beyond their 25th birthday. (To continue coverage, contact the Professional Staff Benefits Office before your dependent's 19th birthday); and
- Children of a qualified same-sex domestic partner. See below for information if you think this applies to you.

Coverage for a Same-Sex Domestic Partner

An eligible, same-sex domestic partner may enroll for coverage on the same basis as a spouse. Throughout this guide, any reference to spousal eligibility should be assumed to include a same-sex domestic partner, unless stated otherwise. Contact your representative for MGH/MGPO Professional Staff benefits for further information. (See side bar)

To be eligible for same-sex domestic partner coverage, you and your partner must be at least 18 years of age and:

MGH/MGPO Professional Staff Questions?

This booklet presents highlights of the benefits program for eligible members of the Professional Staff. Should you require more details on any of these plans, please call the appropriate number listed below or visit the MGPO Professional Staff Benefits Office located at Bulfinch 126.

If your last name begins with a letter between A and K, call 617-726-9264.

If your last name begins with a letter between L and Z, call 617-726-9266.

- Not be married to anyone else or be the domestic partner of anyone else;
- Not be related by blood closer than would bar marriage under the law;
- Be jointly responsible for living expenses in a permanent residence that you share;
- Expect your relationship to be permanent; and
- Agree to notify the appropriate parties in the MGPO Professional Staff Benefits Office of any change in the circumstances of your relationship.

Children of a qualified same-sex domestic partner who live with the domestic partner on a regular basis, or qualify as "dependents" for income tax purposes or are subjects of a court order requiring the domestic partner to provide insurance coverage may be included in the same-sex domestic partner program. However, please note that Federal laws will not permit their participation in a Dependent Care or Health Care Account. Insurance coverage for a same-sex domestic partner or his/her children is paid after-tax and is applied as imputed income.

Your Contributions

Wherever possible, the MGPO has taken advantage of relevant sections of the Internal Revenue Code which allow for tax-favored treatment of employee contributions, if required, for specified programs.

Pre-tax benefits: before federal and state income and Social Security taxes on your contributions are withheld from your pay:

- Medical
- Dental
- Vision
- Flexible Spending Accounts

Pre-tax benefits: before federal and state income taxes are withheld:

- Tax-Sheltered Annuity Program [a 403(b) plan]

After-tax benefits: subject to federal and state income and Social Security taxes:

- Long-Term Disability Insurance
- Supplemental Life and AD&D Insurance
- Spouse and/or Child(ren) Life Insurance

Changes After the Enrollment Period

Open enrollment is held annually, usually in late fall. All choices become effective on the first date of the plan year — each January 1. Newly eligible MGH/MGPO Professional Staff have 30 days to enroll in the Professional Staff Benefits program.

After the enrollment deadline has passed, under IRS regulations you may not add, change or cancel your pre-tax benefit elections until the next plan year, unless you have a qualified change of status.

A qualified change of status occurs if you experience one of the following:

- Marriage or divorce
- Addition of a dependent through birth, adoption or change in custody
- Death of spouse or dependent
- Gain or loss of eligibility for Medicaid, Medicare or other group insurance
- You or your spouse change from benefits-eligible to benefits-ineligible status, or vice versa
- Your spouse's employment ends
- You move out of your HMO's service area
- Gain or loss of full-time student status for dependent age 19 to age 25

The change in coverage you request must be consistent with the change of status that you experience and must be requested within 30 days of the change of status.

Changes to your life insurance elections and Long Term Disability Insurance are allowed after open enrollment. However, adding or increasing insurance coverage is subject to evidence of good health.

Medical

The MGPO offers six medical plans:

- Blue Cross and Blue Shield Partners Plus
- Blue Cross and Blue Shield Partners Value
- Blue Cross and Blue Shield Master Health Plus
- Blue Cross and Blue Shield Master Medical
- Harvard Pilgrim HealthCare
- Tufts Total Health Plan

Coverage levels are available in the following categories:

- Employee
- Family

Choosing a Medical Plan

Before you choose a medical plan, be sure to compare coverage, cost and flexibility under each plan.

Determining Your Medical Coverage Needs

For many people, medical coverage is the most highly valued benefit. The medical plan that is best for you depends on many factors.

- What are your anticipated medical expenses for the coming year?
- How much will you have to pay toward these expenses in deductibles, copayments, and coinsurance?
- Can you opt out of coverage because you have coverage elsewhere — for example, through your spouse's employer?
- Are your doctors participating physicians with Partners Plus, Partners Value, Harvard Pilgrim HealthCare, or Tufts?
- Would you be willing to join a managed care plan in order to pay less for coverage?
- Would you consider a managed care plan where your primary care physician directs all of your medical care needs?
- How well could you withstand unexpectedly high medical expenses if you were to elect a high out-of-pocket cost option such as Partners Value?

Types of Medical Plans

The MGPO offers a variety of medical plans from which to choose. This overview should help you better understand your medical plan options.

The spectrum of choice includes several types of managed care plans and traditional indemnity plans. Managed Care plans require that you select a Primary Care Physician to help direct your care, and they place emphasis on preventive services, such as an annual routine physical, to promote good health. Traditional indemnity insurance plans permit self-directed referrals to specialty care but, generally, insure fewer preventive services.

An increasingly important factor for you to consider is how and where you receive care, as well as the size and scope of the provider network. Managed care plans put together a network of hospitals, physicians and other health care professionals to provide your care. Under these plans, you select a primary care physician (PCP) to coordinate all health care. All the managed care plans MGPO offers maintain large provider networks, and, if you already have a PCP, you may find your doctor in more than one plan. The Partners Plus network includes not only MGH and BWH providers, but also the entire network of HMO Blue medical/surgical providers.

Spectrum of Choice

Health Maintenance Organizations	Point-of-Service Plans	Indemnity Plans
Harvard Pilgrim HealthCare	Blue Cross/Blue Shield Partners Plus	Blue Cross/Blue Shield Master Medical
Tufts Total Health Plan	Blue Cross/Blue Shield Partners Value	Blue Cross/Blue Shield Master Health Plus

Terms to Understand

Primary Care Physician (PCP) — The doctor you select to provide your medical care and/or refer you to a specialist. Each covered family member may select their own PCP.

Copay — The amount you pay per service received, such as office visit, emergency care, prescription drugs, etc. Copays range from $15 to $50.

Deductible — The amount you pay before a plan pays any benefits. For example, if you receive out-of-network care under Partners Plus, you would have to pay $200 (for an individual) or a maximum of $400 (for a family) before the plan would pay benefits.

Coinsurance — The plan's share of the charges that are paid after you have met any deductibles. If a plan pays 80%, for example, you would pay the remaining 20%, up to the plan's annual out-of-pocket maximum.

Out-of-Pocket Maximum — The most you would have to pay in deductibles and coinsurance in a calendar year before the plan pays 100% of covered services. Under Partners Value, for example, your out-of-pocket maximum is $2,000 per individual and $4,000 per family, when you receive care in-network. After you reach your maximum, including your deductible and copayments, the plan would pay 100% of all remaining covered expenses you incur during the year.

Calendar-Year Maximum — The most a plan will pay in a calendar year for a certain benefit for each covered person.

Special Note: Mental Health and Substance Abuse Benefits

Several of the plans require that you get pre-authorization before you receive mental health or substance abuse care.

Recognizing the importance of treatment and the severe financial burden associated with certain biologically-based mental illnesses. Inpatient and outpatient treatment for certain severe biologically-based mental illnesses will be covered at the same level as any other illness. Refer to your health plan for more details.

A Special Note About Partners Plus and Partners Value — Point-of-Service Plans

Partners Plus and Partners Value are Point-of-Service (POS) plans. With POS plans you enjoy the benefits of a managed care plan — access to cost-effective, high-quality care — with the freedom of choice of an indemnity plan. For many employees, these programs offer the right combination of coverage, freedom of provider choice and affordability.

You may use a POS plan just as you would an HMO, receiving care from network providers under the direction of your PCP. Or, you have the freedom of choice to receive care from a non-network provider, without your PCP's referral, at reduced benefit levels.

Your choice of a PCP generally determines which hospitals and specialists within the network will be available to you, and only your PCP can refer you to other providers if you wish to remain in the network. (A special provision of Partners Plus and Partners Value allows your PCP to refer you to MGH or BWH or other Partners HealthCare System participating providers or hospitals for specialty care, regardless of where your PCP practices, at in-network benefit levels.)

After balancing all the factors, many employees have concluded that a point-of-service plan is the choice that best meets their needs.

Selecting Your Primary Care Physician (PCP)

If you enroll in Partners Plus, Partners Value or any of the HMOs, you must select a PCP for yourself and for each family member. If you do not select a PCP, you will not be able to take advantage of your coverage, so it is very important that you complete the PCP selection form for the plan you select.

If you would like help in selecting a primary care physician, help is available. Call the MGH Physician Referral Service at 617-726-5800 or the BWH Physician Referral Service for assistance at 617-732-8288.

If you find it more convenient to choose a PCP close to home, you'll find Partners affiliates and PCHI affiliates in many Massachusetts communities: Massachusetts General Hospital; Brigham and Women's Hospital; Faulkner Hospital; Newton-Wellesley Hospital; North Shore Medical Center: North Shore Children's Hospital; Salem Hospital; and Union Hospital.

Highlights of Medical Plan Options

Point-of-Service Plans

Blue Cross Blue Shield Partners Plus

In-Network

- No annual deductible: plan pays 100% of most covered expenses
- 100% coverage for inpatient services
- $15 copay for office visits and hospital outpatient visits
- $15 copay for routine physicals for adults and children

Out-of-Network

- $200 annual deductible per individual, $400 per family
- 80% coverage for most services
- Maximum annual out-of-pocket cost: $2,000 per individual, $4,000 per family

Blue Cross Blue Shield Partners Value

In-Network

- $250 annual copay per person for inpatient admissions
- 80% coverage for inpatient services
- $35 copay for office visits and hospital outpatient visits
- $35 copay for routine physicals for adults and children
- Maximum annual out-of-pocket cost: $2,000 per individual, $4,000 per family

Out-of-Network

- $500 annual deductible per individual, $1,000 per family
- 70% coverage for most services
- Maximum annual out-of-pocket cost: $4,000 per individual, $8,000 per family

Partners Plus and Partners Value

A special provision of Partners Plus and Partners Value allows your primary care physician to refer you to MGH or Brigham & Women's Hospital for speciality care covered at full benefit levels, regardless of where your primary care physician practices.

Indemnity Plans

Blue Cross Blue Shield Master Health Plus

- No annual deductible: Plan pays 100% of most covered expenses
- 100% coverage for inpatient services
- $15 copay for office visits; $30 copay for hospital outpatient visits

Blue Cross Blue Shield Master Medical

- $25 quarterly individual deductible, $50 quarterly family deductible
- 100% coverage for inpatient services
- 80% coverage on all other covered services/prescriptions

Health Maintenance Organizations

Harvard Pilgrim HealthCare

- Health Maintenance Organization (HMO)
- No annual deductible
- 100% coverage for inpatient services at affiliated hospitals
- $15 copay for office visits and outpatient visits

Tufts Total Health Plan

- Managed care network
- No annual deductible
- 100% for authorized inpatient services
- $15 copay for office visits

Prescription Drug Coverage

When you need to fill a prescription, you can go to any pharmacy that participates with the Medco Health network and show your pharmacy identification card.

Prescription drug coverage is provided by Medco Health based on an open formulary. A formulary is a list of covered prescriptions. The vast majority of therapeutic drugs are included in the formulary. Non-therapeutic drugs, such as those used for cosmetic reasons, are not included.

Co-payments are designed to promote the use of equally-effective, less expensive medications where clinically appropriate. Co-payments are based on the drug's designation in the formulary — generic, preferred, or non-preferred brand-name. This designation is based on the recommendations of the Drug Therapy Committee of the MGH/MGPO and the Pharmacy and Therapeutics Committee of BWH. The existing formulary list is reviewed periodically throughout the year.

Preferred brand name drugs which have a generic equivalent will be covered at the non-preferred brand name copay level — $25.

	Filled at retail pharmacy (Up to 30-day supply)	(Up to 60-day supply)	Filled online or by mail order (90 day supply)
Generic	$ 5	$10	$10
Preferred Brand	$10	$20	$20
Non-preferred Brand	$25	$50	$50

ID Cards, Website Information

If you enroll in a medical plan, you will receive a separate Medco Health identification card for your prescription drug coverage and an information package listing participating pharmacies and non-preferred brand-name drugs. Information is also available on the web at www.medco health.com and by phone at 1-800-711-4541.

Dental

The MGPO offers two dental plans:

- Delta Dental Major Dental
- Delta Dental Basic Dental

The plans offer different benefits, so be sure to review the two options carefully. Then select the plan that is best for you.

Determining Your Dental Coverage Needs

Whether you need dental care coverage depends on several factors. Your family dental history is probably the most important.

To make the right decision, consider the following:

- What is your own dental history?
- Do you or a member of your family need special or recurring treatment, such as orthodontia or periodontics?
- Do you need coverage for yourself only or for your whole family?
- Are you covered elsewhere? Could you be? At what cost?
- Do you need only routine check-ups and cleanings?
- Do you often need restorative dental care?
- Do you often need fillings and crowns?
- How much did you and your family members spend on dental care last year?

Highlights of Coverage

Delta Dental — Major Dental

The plan pays 100% of the charges for diagnostic and preventive care, which includes a checkup and cleaning every six months. Then,

- After you pay a $25 annual deductible ($50 per family), the plan will pay:
  - 80% of the charges for minor restorative treatment
  - 50% of the charges for major restorative treatment
- Maximum benefit: $2,000 per person annually
- Orthodontia benefit (for children only): 50% coverage, no deductible. The plan pays a lifetime maximum benefit of $2,000 per child under age 19.

Delta Dental — Basic Dental

The plan pays 100% of the charges for diagnostic and preventive care, which includes a checkup and cleaning every six months. Then,

- After you pay a $50 annual deductible ($100 per family), the plan will pay:
  - 50% of the charges for minor restorative treatment
  - 50% of the charges for major restorative treatment
- Maximum benefit: $1,000 per person annually

No orthodontia coverage is available under Basic Dental.

Dental Services Calendar year maximum	Major Dental $2,000 per person (excluding orthodontia)	Basic Dental $1,000 per person
DIAGNOSTIC/PREVENTIVE SERVICES		
Complete initial exam and charting—once		
Recall exams every six months		
X-rays: full mouth—every 60 months; bitewings—every 12 months for adults, every six months for children under age 19	100% COVERAGE	
Single tooth X-rays as needed		
Models and casts—every 60 months	NO DEDUCTIBLE	
Preventive Services		
Cleaning, scaling, polishing—every six months		
Fluoride treatment—every six months for members under age 19		
Space maintainers—for members under age 19		
Sealants for unrestored permanent molars, once every 48 months for children under 14		
MINOR RESTORATIVE		
Restorative Services		
Amalgam (metal) and composite resin (natural color) fillings—once every 12 months per surface, per tooth		
Temporary fillings—once per tooth		
Stainless steel crowns (baby teeth only)—once every 24 months per tooth		
Oral Surgery		
Simple extractions (non-surgical) in dentist's office		
Surgical extractions, (including impactions) in dentist's office (If surgery provided in surgical day care or hospital, patient must seek benefits from medical insurance)		
Periodontics	AFTER A $25 INDIVIDUAL DEDUCTIBLE, $50 FAMILY, 80% COVERAGE	AFTER A $50 INDIVIDUAL DEDUCTIBLE, $100 FAMILY, 50% COVERAGE
Periodontal prophylaxis—once every three months following active treatment		
Scraping of inner gum pockets—once every 24 months		
Gingivectomy—in dentist's office (If gingivectomy performed in surgical day care or hospital, patient must seek benefits from medical insurance)		
Endodontics		
Root canal therapy—once per tooth		
Pulpotomy—to age 14		
Prosthetic Maintenance		
Denture repairs—once every 12 months, same repair		
Rebase of dentures—once every 36 months		
Recementing crowns, inlays and onlays—once every 12 months per tooth		
Emergency Dental Care		
Palliative Treatment—three times in six months		
General Anesthesia (only with covered surgical services)		
MAJOR RESTORATIVE		
Prosthodontics		
Dentures	50% COVERAGE	
Fixed bridges and crowns (when part of a bridge)—once every 60 months		
Restorative Services		
Crowns, inlays, onlays (when teeth cannot be restored with regular fillings)—once every 60 months per tooth	AFTER PLAN DEDUCTIBLE	
ORTHODONTIA		
Active orthodontic treatment for children under age 19	50% coverage, no deductible	Not available
Lifetime orthodontia maximum	$2,000 per child under age 19	N/A

Vision

The MGPO offers one option:

- Davis Vision Care Plan

Coverage levels are available in the following categories:

- Employee
- Family

Determining Your Vision Care Needs

Vision care is necessary to maintain good health. Periodic vision examinations not only determine the need for corrective eyewear, but also may detect the presence of general health problems in their early stages. To help determine your insurance need, consider the following:

- What are your anticipated vision care expenses?
- Would you be willing to use a network of private optometrists for your vision care services?

Highlights of Coverage

Get the most value from the Plan, call Davis Vision at 1-800-999-5431 or visit their website at www.davisvision.com for the name of a provider near you. Don't forget that Davis Vision has providers conveniently located near work at Charles River Plaza and other locations. Once you select a Davis provider, call to schedule an appointment.

- An eye examination, after you pay a $10 annual deductible
- One pair of eyeglasses, with plain or tinted lenses
- You can also choose to go out-of-network for reduced benefits

Here is an overview of Vision Care Plan benefits.

Plan Provisions	In-Network Provider	Out-of-Network Provider
Eye Exams	100% after you pay $10 annual deductible	Covered up to $16
Eyeglasses or Contact Lenses	One pair of eyeglasses or contact lenses covered in full or $45 credit toward certain contact lenses – Eyeglass frames from Davis Designer selection 100% Vision lenses 100% – Single lenses – Bifocal lenses – Trifocal lenses or – Contact lenses 100% after you pay $25-$45 for standard, soft-daily wear, disposable or planned replacement contact lenses*	Reimbursement levels: – Frames $14 One pair of lenses: – Single lenses $14 – Bifocal lenses $23 – Trifocal lenses $32 One pair of contact lenses $45
Coverage Frequency	Once every 12 months	Once every 12 months

The plan also covers glass gray #3 prescription lenses and photogray Extra® PGX (sun-sensitive) glass lenses.

*Your Davis provider will give you specific copayment information for the type of lenses you require or prefer.

Long-Term Disability

Long-Term Disability benefits provide you with 60% of your base pay after 90 days of disability. This benefit when integrated with your Primary Social Security Disability benefit and other sources of disability income will assure up to 70% income replacement. However, any coverage you may have from individual disability policies will not be considered.

Highlights of Coverage

- Long-Term Disability benefits provide you with 60% of your base pay after 90 days of disability. This benefit when integrated with your Primary Social Security Disability benefit and other sources of disability income will assure up to 70% income replacement. However, any coverage you may have from individual disability policies will not be considered.
- $30,000 maximum monthly benefit.
- Definition of disability is as 'unable to perform the duties of one's sub-specialty of medicine'. (Per letter of agreement with the Insurance Company).
- Insure all practice income, rather than base salary. (A bonus unrelated to one's practice of medicine would not be insured.)
- Coverage of partial disability on income loss exceeding 20%.
- No offsets for any disability benefits provided by an individual policy.
- Duration to age 65, if disabled before age 60. Otherwise a maximum duration of 4¾ years to age 70, or one year if disabled after age 70.
- Opportunity to convert current monthly benefit amounts up to $20,000 to an individual contract at termination.
- Coverage for Infectious/Contagious Diseases, when the medical condition is considered to pose a real or potential risk to others the Professional Staff member may come in contact with in the performance of the duties of his or her occupation.
- New employees will be subject to a "3 month/12 month" pre-existing conditions clause. This means if a participant has been treated for a condition within 3 months of first becoming eligible for insurance, the participant will not be insured for this condition until they have participated for at least 12 months. (This condition is waived for new participants who have been covered by a comparable group insurance plan for 12 months.)
- If you pay your Long-Term Disability Plan premium through taxable payroll deductions, this benefit when claimed will be paid tax-free. Thus, the insurance represents full after-tax replacement income for most participants.

Customized LTD for Academic Medicine

The Long-Term Disability Plan provides special protection related to your profession and includes partial disability benefits.

Changes to your long-term disability or life insurance elections are allowed after open enrollment. However, you will need to provide proof of good health if you wish to add or increase coverage.

Additional MGPO Policies that Concern Those Receiving LTD Payments:

- Disabled participants in the plan receive continued:
  - Health, dental and vision coverage at the same rate as active employees;
  - Basic group life insurance coverage at no cost;
  - Supplemental group life insurance coverage at the same rate as active employees; and
  - Pension plan contributions.

Life Insurance

The MGPO offers several life insurance plans:

- Basic Group Term Life Insurance
- Supplemental Term Life Insurance
- Spouse Term Life Insurance
- Dependent Term Life Insurance
- Supplemental Accidental Death and Dismemberment Life Insurance
- Business Travel Accident Life Insurance

The MGPO sponsors several life insurance plans intended to protect the varied interests and needs of our members. These insurance plans permit a wide range of protections at cost-effective group rates.

Determining Your Need for Life Insurance Coverage

Everyone has different needs for life insurance. For some, the Basic Group Term Life Insurance benefit is enough. Others need more insurance to help their survivors. To determine how much life insurance you need, consider the following:

- Does someone other than yourself count on your income?
- How much income would be required to maintain your family at their current living standard over the next 3 to 5 years?
- Do you have a very important future event to protect with insurance, such as children's education or payoff of the mortgage on your home?

If the answer to any of these questions is "yes," consider your options to buy additional coverage.

Highlights of Coverage

Basic Group Term Life Insurance

- You will be covered for life insurance equal to one times your annual base salary to a maximum of $1,000,000 on a guaranteed issue basis.
- You may limit this insurance to a maximum of $50,000 if desired. Contact your representative for Professional Staff benefits if you would like to do so. (See sidebar on page 3)

Imputed Income

There is no charge for basic group term life insurance coverage; however, the value of this insurance that exceeds $50,000 will be subject to federal income and Social Security taxes. The value of your life insurance over $50,000 is called "imputed income," and is determined using your age, coverage amount, and the IRS schedule shown on a separate rate sheet. The amount of imputed income resulting from your basic group term life insurance is called "Excess Life" and is reported on your monthly check stub and on your annual W-2 form.

Life Insurance for Every Need

Depending upon your personal needs, you may insure yourself, your spouse and/ or your dependents through the MGH/MGPO group term life insurance programs.

Reductions Due To Age

Basic Term Life Insurance reductions will occur due to attainment of age.

– At age 70 reduces to 50%

– At age 75 reduces to 35%

– At age 80 reduces to 25%

– At age 85 reduces to 20%

– At age 90 reduces to 15%

– At age 95 reduces to 10%

There are no age reductions applied to Supplemental Term Life Insurance while actively at work

Beneficiary Designations

When you are enrolling for life and AD&D insurance, it is important to keep your beneficiary designations current. Your beneficiary is the person(s) who will receive payment of your benefit in the event of your death. You may designate a separate beneficiary for Basic and for Supplemental group term life insurance.

If both you and your spouse (or same-sex domestic partner) are covered by this insurance policy, you cannot cover each other for spouse life insurance. In addition, you cannot both cover your children under dependent child(ren) life insurance.

Supplemental Group Term Life Insurance

- You may also purchase additional term life insurance in amounts equal to 1, 2, 3, 4 or 5 times your annual base salary up to a maximum of $2,000,000, including Basic coverage.
- Newly eligible Professional Staff Members can enroll for up to $1,000,000 of coverage with no evidence of insurability required if enrolled within 90 days of first eligibility. If the combined amount of your Basic and Supplemental insurance is in excess of $1,000,000, you will have to submit evidence of insurability to be reviewed by the insurance company before the insurance becomes effective.
- The insurance premium is based on your age.
- Up to $500,000 of supplemental life insurance may be portable if you terminate, retire or transfer (but not if you are disabled, in the military, or due to certain other restrictions). If you would like more information about portability, or if you are interested in pursuing your entitlement to portable supplemental life insurance, please contact your MGPO Professional Staff Benefits Office.

Spouse Term Life Insurance

- You may purchase term life insurance for your spouse in $25,000 increments up to a maximum of $100,000, but not to exceed 50% of the amount of supplemental term insurance coverage you have elected for yourself. Except when first eligible, Spouse Life Insurance will require showing evidence of good health.
- On amounts to $50,000, no proof of good health is required if enrolled within 30 days of initial eligibility.

Child Dependent Term Life Insurance

- Coverage of $2,000, $5,000 and $10,000 for your children age 6 months to 25 is available.
- Children 14 days to 6 months are insured for $500.

Employee Supplemental Accidental Death and Dismemberment Insurance

- Supplemental Insurance is available in amounts equal to 1, 2, 3, 4 or 5 times your annual base salary, up to a maximum of $2,000,000. (Employee Supplemental AD&D cannot be greater than twice the multiples selected under Employee Supplemental Term Insurance.)

Spouse Accidental Death and Dismemberment Insurance

- You may purchase AD&D Insurance for your spouse in $25,000 increments to a maximum of $100,000. (Spouse AD&D cannot be greater than twice the value of Spouse Term Life Insurance.)

Business Travel Accident Insurance

- Most MGPO employees are insured for 3 times base pay up to $1,000,000 if accidental death or dismemberment occurs while traveling on Hospital business.
- The MGPO pays the full cost of this coverage.

Your Spending Accounts

The MGPO offers two options:

- Health Care Account
- Dependent Care Account

Highlights of Participation

Spending Accounts let you take advantage of laws that allow you to save on taxes for certain health care and dependent care expenses. There are two separate accounts — one for health care expenses not covered by your medical, dental, or vision plans, and one for dependent care expenses.

- Health Care Account — You may set aside up to $3,000 each year to pay for uninsured medical, dental, and vision expenses with before-tax dollars.
- Dependent Care Account — You may set aside up to $5,000 each year to pay for eligible dependent care expenses with before-tax dollars.

Save on Taxes

When you participate in a Health Care Account, a Dependent Care Account, or both accounts, you save at least 20% on your eligible expenses.

Determining Your Need for a Health Care Account

To determine the level of expenses you are likely to incur, review what you have spent on medical expenses for the last two years. You should also consider how your choice to participate in a particular benefit plan, such as dental or vision coverage, may affect the amount you might contribute.

The examples of eligible expenses shown on the left may help you determine what types of unreimbursed medical expenses you may claim with your Health Care Account. In general, most health care expenses (medical, dental, vision, hearing, etc.) can be paid through your Health Care Account, as long as they are considered eligible medical expenses on your federal income tax return.

The IRS does not recognize a same-sex domestic partner and his/her children as dependents for tax purposes. As a result, their expenses are not eligible for reimbursement through a Health Care Account.

Examples of Eligible Health Care Expenses

Remember: With the range of medical, dental, and vision plans available through the MGPO, some of these expenses may be partially or fully covered, depending upon your personal selections. Any amount covered by your plans is not an eligible expense.

- **Dental Care** — all uninsured dental care including deductibles, coinsurance, and amounts over maximums;
- **Vision Care** — exams, and all vision aids not covered by your plan, laser vision correction treatment;
- **Hearing Care** — exams not covered by your medical plan, hearing aids and batteries;
- **Prescription Drugs** — not covered by your plan, copays
- **Outpatient Psychiatric Care** — over benefit maximum; and
- **Health Care** — deductibles, co-payments, coinsurance, regular checkups and other expenses not covered by your plan (as long as they would qualify for the federal income tax deduction); these expenses include:
  - Prosthetic or orthopedic devices;
  - Special medical equipment;
  - Psychological or psychiatric care;
  - Occupational therapy;
  - Acupuncture;
  - Nursing services; and,
  - Other health care expenses such as annual physicals, immunizations, and vaccinations.

In addition to the specific covered expenses noted above, the program will reimburse you for most other health care expenses that would be deductible under the Internal Revenue Code, except for insurance premium payments and long term care expenses or premiums.

Determining Your Need for a Dependent Care Account

A Dependent Care Account allows you to set aside tax-free dollars to pay for dependent care expenses you incur so that you (and your spouse, if you are married) can work. You may also use a Dependent Care Account if your spouse is attending school full time or is disabled. You may set aside up to $5,000 each year.

The IRS does not recognize a same-sex domestic partner and his/her children as dependents for tax purposes. As a result, their expenses are not eligible for reimbursement through a Dependent Care Account.

Examples of Eligible Dependent Care Expenses

- Nursery schools, day care centers, and summer day camps;
- Dependent care providers in or outside your home;
- Dependent care centers that provide day care (not residential care) for dependent adults; and
- A housekeeper or cook, if services are provided in part to a person who qualifies for dependent care.

Note: A relative who provides dependent care services may be paid for through this account, as long as the relative is not your (or your spouse's) dependent, and is not your child or stepchild who is under age 19 at the end of the year. To be eligible for reimbursement from your Dependent Care Account, your day care provider must submit a Social Security or tax provider identification number.

Expenses for your dependent children are eligible until your child reaches age 13. If you are caring for an elderly family member whom you claim as a dependent for income tax purposes, you may also submit these expenses to your Dependent Care Account.

Deciding How Much to Set Aside in Your Dependent Care Account

Before you decide how much to contribute to your Dependent Care Account, consider:

- Holidays and vacations during which your dependent care needs might change;
- Whether one of your dependents will begin school during the year and need less dependent care; and
- Whether any of your dependents will become ineligible during the year (for example, by reaching age 13).

To qualify for reimbursement, your dependent care expenses cannot exceed the earned income of the lesser-earning spouse.

Internal Revenue Service Rules: Use It or Lose It

Be sure to estimate your health care and dependent care expenses carefully. Under IRS rules, you must forfeit any unused account balance(s) remaining at year end. Generally you cannot change or stop contributing during the year unless you have a qualified change of status. You have until March 31 of the subsequent year to submit for reimbursement any expenses you incurred before the end of the previous calendar year.

For a complete list of eligible expenses, go to the IRS website (http://www.irs.ustreas.gov/prod/forms_pubs/pubs.html) and print off the publications.

Retirement

The MGPO provides several sources for retirement income:

- Academic Annuity
- Future Income Plan
- Tax Sheltered Annuity Program

Academic Annuity Plan (AAP)

The Academic Annuity Plan is a "defined contribution" retirement plan. Contributions are based on your age and salary. You will be asked to decide how these contributions will be invested for your retirement. Therefore, you will have a very significant role in determining how much you will have saved for retirement.

- You may direct these contributions to sponsored funds at TIAA-CREF, at Fidelity Investments and at the Vanguard Group. Each investment company offers a variety of educational materials to familiarize you with your investment options. These materials are available in the Professional Staff Benefits Office (Bulfinch 126).

Amount the Hospital Contributes

The federal government limits the amount of annual compensation an employer can recognize in a pension plan calculation. Effective January 1, 2002, "maximum recognizable compensation" is set at $200,000. The amount may increase in the future.

Also, the Academic Annuity Plan percentage contribution differs on "recognizable compensation" under and over the "Taxable Wage Base." The Taxable Wage Base is the amount of annual earnings subject to the Federal Insurance Contributions Act (FICA) taxation related to Old Age, Survivors and Disability Insurance (OASDI). For 2003, the Taxable Wage Base is $87,000.

- If you are under the age of 40, MGH and/or MGPO (depending on funding sources) will contribute an amount equal to 5% of your regular earnings up to the Taxable Wage Base and 10% on regular earnings over the Taxable Wage Base to the "maximum recognizable compensation" limit.
- If you are age 40 or over, MGH and/or MGPO (depending on funding sources) will contribute an amount equal to 11% of your regular earnings up to the Taxable Wage Base and 16% on regular earnings over the Taxable Wage Base to the "maximum recognizable compensation" limit.

Please note these general plan rules may, at times, be further limited by IRS regulations.

Eligibility

The Academic Annuity Plan is available after one year of eligibility service to all Professional Staff who hold a Harvard University academic appointment of Instructor or higher. Spaulding Rehabilitation Hospital Professional Staff and Institute of Health Professions faculty and executive staff are also eligible.

Residents, Fellows, and Graduate Assistants are not eligible for this plan.

Future Income Plan (FIP)

If you are a member of the Professional Staff and hold a Harvard University appointment of Instructor or higher, but you are without the required year of eligibility service for participation in the Academic Annuity Plan, or if your income exceeds IRS imposed limits (see "maximum recognizable compensation" on page 25), you are eligible for the Future Income Plan.

- For the first year of your employment, the Hospital will calculate what would have been paid into the AAP had you been eligible, and the Hospital will pay it to you as FIP instead. FIP is taxable income to you.
- If you are already a member of the AAP and your salary exceeds the "maximum recognizable compensation," you will also receive contributions to the FIP on some earnings exceeding the "maximum recognizable compensation."

See your Professional Staff Benefits Representative for details. You may wish to set this money aside for retirement purposes by using the Tax Sheltered Annuity Program or by purchasing an after-tax annuity.

When combined, contributions to the AAP and the FIP may not exceed $40,000.

Tax Sheltered Annuity Program (TSA)

- You may set aside a portion of your pay to purchase a tax-sheltered annuity (TSA) to supplement your retirement income.
- A TSA offers you the opportunity to reduce current income taxes, defer taxes on your investment earnings and save for your retirement.
- Since your eligibility to make tax-deductible contributions to an Individual Retirement Account (IRA) is affected by pension plan membership and income levels, participation in the TSA can be an excellent alternative.
- You may enroll in the TSA Program at any time.
- The maximum annual contribution is limited to $12,000 in 2003. This limit will increase by $1,000 each year through 2006.
- If you are over age 50, for 2003, you may contribute an additional $2,000. Also, if you have 15 years of service with MGH and have not already invoked the "catch-up provision" you might be eligible to contribute an additional $2,000 to the TSA program for 2003.
- At the time you enroll, you will need to decide how to invest your savings.
- The Professional Staff Benefits Office can provide you with information on the investment options available.
- Early access to money contributed to a TSA program is limited, and penalties apply to any funds withdrawn prior to age 59½.

Before you enroll in a TSA, please stop by or call the Professional Staff Benefits Office for a complete description of the program.

Malpractice Insurance

Staff physicians who conduct at least 75% of their clinical activity at CRICO shareholder institutions are eligible for malpractice insurance if they also are paid an annual MGH salary of at least $15,000 or hold a Harvard Medical School appointment of Instructor or higher, and have an office at MGH.

- The policy is underwritten by the Controlled Risk Insurance Company of Vermont (a Risk Retention Group), better known as CRICO.
- The current limits of liability are $5,000,000 each claim, $10,000,000 annual aggregate for each physician, dentist, and podiatrist.
- The policy provides insured with "tail coverage" for claims made subsequent to your departure but arising out of medical incidents that occur during the period of your participation in the program.

You must complete a malpractice registration form in the Professional Staff Benefits Office to be covered by this policy.

For more information about CRICO visit the Risk Management Foundation website at www.rmf.harvard.edu

Additional Benefits

Massachusetts General Hospital is a large community and extends to its employees a vast array of conveniences and services that make working at MGH/MGPO a pleasure. Just a few are listed here:

- **Child Care** — The Hospital is pleased to offer quality on-site day care at the MGH Children's Center, located in the historic Captain's Quarters building in the Charlestown Navy Yard. Back-up child care is also available on-site at MGH. For information on rates and available space, contact the Children's Center at 617-726-KIDS.
- **Harvard University Employees' Credit Union** — Available to all MGH/MGPO employees for savings and loans through payroll deduction.
- **The Partners "Perks" Program** — Offers special discounts on products and services of interest to MGH/MGPO employees and family members.
- **Direct Deposit** — Enjoy the convenience of having your paycheck automatically deposited into your bank account.
- **Charles River Park Fitness Center** — Discount membership available.

Your COBRA Rights

When you or your covered dependents are no longer eligible for coverage under your MGH medical, dental or vision care plan, you or your covered dependents may be eligible to continue this coverage as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA). To continue your coverage (or your dependents' coverage), you will pay up to 102% of the premium cost. This law applies to you if you lose eligibility for coverage due to:

- Termination of employment (for reasons other than gross misconduct);
- Reduction of work hours;
- Divorce or legal separation;
- Your death;
- Your entitlement to Medicare benefits; or
- Loss of status as an eligible dependent.

If you have questions about COBRA coverage, contact the Professional Staff Benefits Office at:

- 617-726-9264 if your last name begins with a letter between A and K; or
- 617-726-9266 if your last name begins with a letter between L and Z.

The period of COBRA coverage begins with the date of your qualifying event and continues for up to 18 months from that qualifying event in most cases. If you continue your coverage under COBRA due to divorce or loss of status as an eligible dependent, however, COBRA coverage is available for 36 months. If you are qualified for disability under Title II or Title XVI of the Social Security Act after you accept COBRA coverage, your COBRA coverage continues for up to 29 months. You will pay up to 150% of the premium cost during the 19th through 29th months.

How to Enroll for COBRA Continuation Coverage

To enroll for continuation coverage under COBRA, complete a COBRA election form, which will be mailed to you upon termination from the Hospital or upon reduction in work hours, or which is available from the Professional Staff Benefits Office. Divorced spouses or individuals who lose status as eligible dependents should call the Professional Staff Benefits Office. Return your completed election form to the address on the form within 60 days from your date of termination of coverage or your notification of COBRA eligibility, whichever is later. If you do not return your completed form, the Hospital will assume that you are waiving continued coverage under COBRA, and you will not be allowed to continue your coverage in the plan. (The 60 days will be counted from the date of the COBRA eligibility notice to the postmarked date of your mailed election form.)

When Your COBRA Coverage Ends

Your COBRA coverage will end when:

- You reach the maximum length of time allowed for your COBRA coverage (for example, 18 months or 29 months or 36 months from your qualifying event). (If you are continuing your coverage beyond 18 months due to disability, your coverage will end when you are no longer disabled or after 29 months, whichever is sooner.);
- You fail to make timely payment of your COBRA premiums;
- You enroll in another employer-sponsored health care plan and that plan does not include pre-existing conditions limitations or waiting periods; or
- You become entitled to Medicare benefits.

In addition, your COBRA coverage described in this guide will end when the Hospital terminates its agreement with the health care companies which administer the plans. In this case, your COBRA coverage may continue.

HIPAA Provision

If You Declined Medical Coverage Because You Have Coverage Elsewhere

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you may have the opportunity to enroll yourself and your eligible dependents for medical coverage during the year if you previously declined coverage as follows:

- You and/or your dependents have coverage from another source (such as your spouse's medical plan or COBRA coverage) and you lose that coverage, or
- You acquire a dependent through marriage, birth, adoption or placement for adoption.

If you need to enroll for coverage as a result of one of the above events, you must do so within 31 days of the event. Otherwise, you may be required to wait until the next open enrollment period.

EX. 6

Benefits for Professional Staff

BWPO

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BRIGHAM AND WOMEN'S/FAULKNER HOSPITALS
Member of the PARTNERS HealthCare System

BWPO

BRIGHAM AND WOMEN'S
PHYSICIANS ORGANIZATION

Excellence and innovation in academic medicine

PHS 003264

BWPO PENSION PLAN BENEFITS

MEDICINE

Below is a summary of the contribution levels and vesting schedule that apply to Medicine department physicians. Please refer to the BWPO Benefits for Professional Staff enrollment guide for more detailed information on your pension benefits.

Contributions on Medicine Salary Sources

The PO makes contributions to the plan based on your age and salary* under a formula identical to that of the BWH:

- If you are under age 40 on June 30, the PO will contribute an amount equal to **5%** of your Medicine salary up to the Social Security wage base**, and **10%** of your Medicine salary above the Social Security wage base.

- If you are age 40 or over on June 30, the PO will contribute an amount equal to **11%** of your Medicine salary up to the Social Security wage base, and **16%** of your Medicine salary above the Social Security wage base.

*Up to $170,000 currently, as well as any further limits imposed by the IRS.
**The Social Security wage base is $80,400 for 2001, and is adjusted annually.

Vesting on Medicine Contributions

You will be 100% vested in your account after you have met the plan's eligibility requirements. Those requirements are indicated in the retirement section of the BWPO Benefits for Professional Staff enrollment guide.

11/16/00

Table of Contents

Highlights

The Professional Staff Benefits Program is designed with the advice and counsel of members of the BWPO to meet the interests and needs of BWPO members and their families.

Featured are:

- Six medical plans to protect you and your family in the event of illness or injury.
- A dental plan offering coverage for basic, major and restorative care.
- A vision care plan providing cost-effective coverage for eye examinations and corrective lenses.
- Individual or family levels of coverage (including a qualifying same-sex domestic partner), for medical, dental, and vision care so that you can tailor coverage to fit your situation.
- Generally, payroll deductions for medical, dental and vision care are made on a pre-tax basis.
- Two Spending Accounts offering tax savings for eligible health care, dependent child and adult day care expenses.
- Long-Term Disability Insurance for financial protection in the event you cannot work due to an extended illness or injury.
- Basic group term life insurance in an amount equal to your annual salary to provide survivor protection.
- Supplemental group term life insurance in amounts up to five times your annual salary.
- Supplemental life insurance for your spouse and dependent children.
- Accidental death and dismemberment insurance equal to your annual salary.
- A defined contribution pension plan (the Professional Staff Retirement Plan) allows participant-directed investment opportunities.
- A Tax Sheltered Annuity program permitting voluntary tax deferred retirement savings to supplement pension plan savings.
- Other benefits including: Longwood Medical Area Child Care Center, back-up child care through Parents-in-a-Pinch, Medical Area Federal Credit Union.

Your costs associated with these plans appear on an insert in the back of this booklet.

Eligibility

To participate in the BWPO Benefits Program you must:

- Be a member of the Professional Staff, with a regular annual salary of at least $6,000.

Selecting Your Coverage Levels

When you enroll for medical, dental and vision care coverage, you may enroll in different coverage levels for each benefit. For example, you could enroll in Family coverage for medical, and Employee coverage for dental.

Your options include:

- Employee (yourself only)
- Family (yourself, your spouse or same-sex domestic partner, and your dependent unmarried children under age 19)

Eligible same-sex domestic partners may enroll for coverage on the same basis as a spouse. Please see the information provided on page 4 if you are interested in coverage for a same-sex domestic partner and/or children of a same-sex domestic partner.

Eligible Dependents

You may enroll your dependents for medical, dental, vision and life insurance coverage if they are in one of the following categories:

- Your legal spouse or eligible same-sex domestic partner;
- Unmarried children under age 19;
- Unmarried children from age 19 until they reach age 25, as long as they are full-time students. Proof of full-time student status is required;
- Children who are mentally or physically handicapped and incapable of self-support, even beyond their 25th birthday. (To continue coverage, contact the BWPO Human Resources Manager for Professional Staff Benefits before your dependent's 19th birthday); and
- Children of a qualified same-sex domestic partner. See page 4 for information if you think this applies to you.

Questions?

This booklet presents highlights of the benefits program for which you are eligible. Should you require more details on any of these plans, please contact the BWPO Human Resources Manager for Professional Staff Benefits or your departmental human resources representative.

Coverage for a Same-Sex Domestic Partner

An eligible, same-sex domestic partner may enroll for coverage on the same basis as a spouse. Throughout this guide, any reference to spousal eligibility should be assumed to include a same-sex domestic partner, unless stated otherwise. Contact the BWPO Human Resources Manager for Professional Staff Benefits for further information.

To be eligible for same-sex domestic partner coverage, you and your partner must be at least 18 years of age and:

- Not be married to anyone else or be the domestic partner of anyone else;
- Not be related by blood closer than would bar marriage under the law;
- Be jointly responsible for living expenses in a permanent residence that you share;
- Expect your relationship to be permanent; and
- Agree to notify the appropriate parties in the BWPO Benefits Office of any change in the circumstances of your relationship.

Children of a qualified same-sex domestic partner who live with the domestic partner on a regular basis, or qualify as "dependents" for income tax purposes or are subjects of a court order requiring the domestic partner to provide insurance coverage may be included in the same-sex domestic partner program. However, please note that Federal laws will not permit their participation in a Dependent Care or Health Care Account. Insurance coverage for a same-sex domestic partner or his/her children is paid after-tax and is applied as imputed income.

Your Contributions

Wherever possible, the BWPO has taken advantage of relevant sections of the Internal Revenue Code which allow for tax-favored treatment of employee contributions, if required, for specified programs.

Pre-tax benefits: before federal and state income and Social Security taxes on your contributions are withheld from your pay:

- Medical
- Dental
- Vision
- Flexible Spending Accounts

Pre-tax benefits: before federal and state income taxes are withheld:

- Tax-Sheltered Annuity Program [a 403(b) plan]

After-tax benefits: subject to federal and state income and Social Security taxes:

- Long-Term Disability Insurance
- Supplemental Life and AD&D Insurance
- Spouse and/or Child(ren) Life Insurance

Changes After Your Initial Enrollment Period

After your initial 30-day enrollment period you will have the opportunity to make changes annually at "open enrollment", which occurs on a calendar year basis, and you will have the opportunity to make certain changes if you encounter a "qualifying event" as described below.

Qualifying Event

You may change your Medical, Dental or Vision coverage level or your Health Care and/or Dependent Care Account participation when you experience a qualifying change in status. This change must be requested within 30 days of the event and must be consistent with the event. For example:

- Marriage or divorce
- Addition of a dependent through birth, adoption or change in custody
- Death of spouse or dependent
- Gain or loss of eligibility for Medicaid, Medicare or other group insurance
- You or your spouse change from benefits-eligible to benefits-ineligible status, or vice versa
- Your spouse's employment ends
- You move out of your HMO's service area
- Gain or loss of full-time student status for dependent age 19 to age 25

The change in coverage you request must be consistent with the change of status that you experience and must be requested within 30 days of the change of status.

Questions?

This booklet presents highlights of the benefits program for which you are eligible. Should you require more details on any of these plans, please contact the BWPO Human Resources Manager for Professional Staff Benefits.

Medical

BWPO offers six medical plans:

- Blue Cross and Blue Shield Partners Plus
- Blue Cross and Blue Shield Partners Value
- Harvard Pilgrim HealthCare
- Neighborhood Health Plan
- Tufts Health Plan
- Blue Cross and Blue Shield Master Health

Before you choose a medical plan, be sure to compare coverage, cost and flexibility under each plan.

Coverage levels are available in the following categories:

- Employee
- Family

Determining Your Medical Coverage Needs

For many people, medical coverage is the most highly valued benefit. The medical plan that is best for you depends on many factors.

- What are your anticipated medical expenses for the coming year?
- How much will you have to pay toward these expenses in deductibles, copayments, and coinsurance?
- Can you opt out of coverage because you have coverage elsewhere — for example, through your spouse's employer?
- Are your doctors participating physicians with Partners Plus, Partners Value, Harvard Pilgrim HealthCare, Neighborhood Health Plan or Tufts?
- Would you be willing to join a managed care plan in order to pay less for coverage?
- Would you consider a managed care plan where your primary care physician directs all of your medical care needs?
- How well could you withstand unexpectedly high medical expenses if you were to elect a high out-of-pocket cost option such as Partners Value?

Types of Medical Plans

The BWPO offers a variety of medical plans from which to choose. This overview should help you better understand your medical plan options.

The spectrum of options includes managed care plans and a traditional indemnity plan. The major benefit difference between managed care and indemnity plans is that managed care generally provides more coverage for routine and preventive services.

An increasingly important factor for you to consider is how and where you receive care, as well as the size and scope of the provider network. Managed care plans put together a network of hospitals, physicians and other health care professionals to provide your care. Under these plans, you select a primary care physician (PCP) to coordinate all health care. All the managed care plans the BWPO offers maintain large provider networks, and, if you already have a PCP, you may find your doctor in more than one plan. The Partners Plus network includes not only BWH and MGH providers, but also the entire network of HMO Blue medical/surgical providers.

Spectrum of Choice

Health Maintenance Organizations	*Point-of-Service Plans*	*Indemnity Plans*
Harvard Pilgrim HealthCare	Blue Cross/Blue Shield	Blue Cross/Blue Shield
Tufts Health Plan	Partners Plus	Master Health
	Blue Cross/Blue Shield	
	Partners Value	

Partners Plus and Partners Value

With Partners Plus and Partners Value, which are Point-of-Service (POS) plans, you enjoy the benefits of a managed care plan — access to cost-effective, high-quality care — with the freedom of choice of an indemnity plan. For many employees, these programs offer the right combination of coverage, freedom of provider choice and affordability.

You may use a POS plan just as you would an HMO, receiving care from network providers under the direction of your PCP. Or, you have the freedom of choice to receive care from a non-network provider, without your PCP's referral, at reduced benefit levels.

Your choice of a PCP generally determines which hospitals and specialists within the network will be available to you, and only your PCP can refer you to other providers if you wish to remain in the network. (A special provision of Partners Plus and Partners Value allows your PCP to refer you to BWH or MGH or other Partners HealthCare System physicians or hospitals for specialty care, regardless of where your PCP practices, at in-network benefit levels.)

After balancing all the factors, many employees have concluded that a point-of-service plan is the choice that best meets their needs.

Selecting Your Primary Care Physician (PCP)

If you enroll in Partners Plus, Partners Value or any of the HMOs, you must select a PCP for yourself and for each family member. If you do not select a PCP, you will not be able to take advantage of your coverage, so it is very important that you complete the PCP selection form for the plan you select.

If you would like help in selecting a primary care physician, help is available. Call the BWH Physician Referral Service for assistance at (617) 732-8288 or the MGH Physician Referral Service at (617) 726-5800.

If you find it more convenient to choose a PCP close to home, you'll find Partners affiliates and PCHI affiliates in many Massachusetts communities: Brigham and Women's Hospital; Faulkner Hospital; Massachusetts General Hospital; Newton-Wellesley Hospital; North Shore Medical Center: North Shore Children's Hospital, Salem Hospital, and Union Hospital.

Terms to Understand

Copay—The amount you pay per service received, such as office visits, emergency care, prescription drugs, etc. Copays usually range from $5 to $50.

Deductible—The amount you pay before a plan pays any benefits. For example, if you receive out-of-network services under Partners Plus, you would have to pay $200 (for an individual) or a maximum of $400 (for a family) before the plan would pay benefits.

Coinsurance—The plan's share of the charges that are paid after you have met any deductibles. If a plan pays 80%, for example, you would pay the remaining 20%, up to the plan's annual out-of-pocket maximum.

Out-of-Pocket Maximum—The most you would have to pay in deductibles and coinsurance in a calendar year before the plan pays 100% of covered services. Under Partners Value, for example, your out-of-pocket maximum is $2,000 per individual and $4,000 per family when you receive care in-network. After you reach your maximum, including your deductible and copayments, the plan would pay 100% of all remaining covered expenses you incur during the year.

Calendar-Year Maximum—The most a plan will pay in a calendar year for a certain benefit for each covered person.

Special Note: Mental Health and Substance Abuse Benefits

Several of the plans require that you get pre-authorization before you receive mental health or substance abuse care.

Recognizing the importance of treatment and the severe financial burden associated with certain biologically-based mental illnesses, Partners will expand mental health coverage effective January 1, 2001. Inpatient and outpatient treatment for certain severe biologically-based mental illnesses will be covered at the same level as any other illness. Refer to your health plan for more details.

Partners Plus and Partners Value

A special provision of Partners Plus and Partners Value allows your primary care physician to refer you to Brigham & Women's Hospital or MGH for speciality care covered at full benefit levels, regardless of where your primary care physician practices.

Highlights of Coverage

Partners Plus

In-Network

- No annual deductible: Plan pays 100% of most covered expenses
- 100% coverage for inpatient services
- $10 copay for office visits and hospital outpatient visits
- $10 copay for routine physicals for adults and children

Out-of-Network

- $200 annual deductible per individual, $400 per family
- 80% coverage for most services
- Maximum annual employee out-of-pocket cost: $2,000 per individual, $4,000 per family

Partners Value

In-Network

- $250 annual copay per person for inpatient admissions
- 80% coverage for inpatient services
- $20 copay for office visits and hospital outpatient visits
- $20 copay for routine physicals for adults and children
- Maximum annual employee out-of-pocket cost: $2,000 per individual, $4,000 per family (excludes annual $250 per person inpatient copayment)

Out-of-Network

- $500 annual deductible per individual, $1,000 per family
- 70% coverage for most services
- Maximum annual employee out-of-pocket cost: $4,000 per individual, $8,000 per family (excludes annual $250 per person inpatient copayment)

Master Health

- 100% coverage for inpatient services
- 80% coverage for most office visits after $100 deductible (individual), $200 deductible (family)

Harvard Pilgrim HealthCare

- No annual deductible
- 100% coverage for inpatient services at affiliated hospitals
- $10 copay for office visits and outpatient visits

Neighborhood Health Plan

- No annual deductible
- 100% coverage for inpatient services at affiliated hospitals
- $5 copay for office visits

Tufts

- No annual deductible
- 100% coverage for authorized inpatient services
- $10 copay for office visits and outpatient visits

Prescription Drug Coverage

When you need to fill a prescription, you can go to any pharmacy that participates with the Merck-Medco network and show your pharmacy identification card.

Prescription drug coverage is provided by Merck-Medco based on an open formulary. A formulary is a list of covered prescriptions. The vast majority of therapeutic drugs are included in the formulary. Non-therapeutic drugs, such as those used for cosmetic reasons, are not included.

Co-payments are designed to promote the use of equally-effective, less expensive medications where clinically appropriate. Co-payments are based on the drug's designation in the formulary — generic, preferred, or non-preferred brand-name.

	FILLED AT RETAIL PHARMACY		FILLED ONLINE OR BY MAIL ORDER
	(UP TO 30-DAY SUPPLY)	(UP TO 60-DAY SUPPLY)	(90-DAY SUPPLY)
Generic	$ 5	$10	$10
Preferred Brand	$10	$20	$20
Non-preferred Brand	$25	$50	$50

Opt-Out

- If you have other medical coverage, you may decline coverage on your election form.
- Receive a taxable supplement in your paycheck throughout the year.

If you enroll in a medical plan, you will receive a separate Merck-Medco identification card for your prescription drug coverage and an information package listing participating pharmacies and non-preferred brand-name drugs. Information is also available on the web at www.merck-medco.com and by phone at 1-800-711-4541.

Dental

The BWPO offers a dental plan:

- Dental Blue 15 from BlueCross BlueShield of Massachusetts

Coverage levels are available in the following categories:

- Employee
- Family

Determining Your Dental Coverage Needs

Whether you need dental care coverage depends on several factors. Your family dental history is probably the most important.

To make the right decision, consider the following:

- What is your own dental history?
- Do you or a member of your family need special or recurring treatment, such as orthodontia or periodontics?
- Do you need coverage for yourself only or for your whole family?
- Are you covered elsewhere? Could you be? At what cost?
- Do you need only routine check-ups and cleanings?
- Do you often need restorative dental care?
- How much did you and your family members spend on dental care last year?

Highlights of Coverage

When you use participating BlueShield of Massachusetts dentists, the plan pays 100% of the charges for diagnostic and preventive care, which includes a checkup and cleaning every six months. Then, after you pay a $25 annual deductible ($50 per family), the plan will pay:

- 80% of the charges for minor restorative treatment
- 50% of the charges for major restorative treatment
- Maximum benefit: $1,500 per person annually
- Orthodontia benefit of $1,500 lifetime maximum

Benefits for non-participating dentists are provided at lower reimbursement rates.

BC/BS Dental Blue 15

Preventive Benefit Group	Basic Benefit Group	Major Benefit Group	Orthodontic Benefit
No Deductible	$25 per Individual/$50 per Family Calendar-Year Deductible		No Deductible
100%	80%	50%	100%
Diagnostic ■ One complete initial oral exam and charting each 26 weeks ■ Full mouth X-rays each ■ 60 months, 7 or more films, or panaromic X-rays with bitewing X-rays ■ Bitewing X-rays each 6 months ■ Single tooth X-rays as needed ■ Study models and casts each 60 months ■ Periodic or routine oral exams each 26 weeks ■ Emergency exams Preventive ■ Routine cleaning, scaling, and polishing of the teeth each 6 months ■ Fluoride treatment (members under age 19) each 6 months ■ Sealants on permanent molars (members under age 14) one application per molar each 48 months ■ Space maintainers (members under age 19)	Restorative ■ Silver amalgam fillings ■ Composite resin (tooth color) fillings on front teeth ■ Sedative fillings ■ Pin retention for fillings ■ Stainless steel crowns on baby teeth and on first permanent adult molars (members under age 16) Oral Surgery ■ Tooth extractions ■ Root removal ■ Biopsies Periodontics (gum and bone) ■ Periodontal scaling and root planing once per quadrant each 24 months ■ Periodontal surgery (curettage, osseous surgery) once per quadrant each 36 months ■ Periodontal maintenance following active periodontal therapy once each 3 months Endodontics (roots and pulp) ■ Root canal therapy or retreatment root canal therapy once per lifetime per tooth on permanent teeth ■ Therapeutic pulpotomy (members under age 16) ■ Pulp capping ■ Other endodontic surgery Prosthetic Maintenance ■ Repair of partial or complete dentures, crowns, and bridges each 12 months ■ Adding teeth to an existing complete or partial denture ■ Rebase or reline dentures each 36 months ■ Recementing of crowns, inlays, onlays, and fixed bridgework each 12 months Other Services ■ Occlusal adjustments once each 24 months ■ Occlusal guards ■ Services to treat root sensitivity ■ Emergency dental care ■ General anesthesia	Prosthodontics (teeth replacement) ■ Complete or partial dentures (including services to fabricate, measure, fit, and adjust them) once each 60 months for each arch ■ Fixed bridges (including services to fabricate, measure, fit, and adjust them) once each 60 months per tooth ■ Replacement of dentures and bridges once each 60 months ■ Adding teeth to an existing bridge ■ Temporary partial dentures to replace any of the 6 upper or lower front teeth Major Restorative ■ Crowns, inlays, and onlays ■ Replacement of crowns, inlays, and onlays once each 60 months per tooth ■ Post and core or crown buildup once each 60 months per tooth	Orthodontics ■ Complete orthodontic exam ■ Comprehensive or limited active orthodontic treatment including appliances
$1,500 Calendar-Year Benefit Maximum per person			$1,500 Lifetime Benefit Maximum per person

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Vision

The BWPO offers a vision plan:

- BlueCross BlueShield Vision Care

Coverage levels are available in the following categories:

- Employee
- Family

Determining Your Vision Care Coverage Needs

Vision care is necessary to maintain good health. Periodic vision examinations not only determine your need for corrective eye wear, but also may detect the presence of general health problems in their early stages. BlueCross BlueShield administers the Vision Plan for the BWPO.

To help determine your coverage needs, consider the following:

- What are your anticipated vision care expenses?
- Would you be willing to use participating Blue Shield of Massachusetts opthalmologists and optometrists?

Highlights of Coverage

The BlueCross BlueShield Vision Care Plan provides coverage for eye exams when performed by a participating BlueShield of Massachusetts ophthalmologist or optometrist. Eyeglasses or contact lenses are covered. Benefits are based on a reimbursement schedule, as detailed in the following chart.

Covered Service	Benefit Amount
Eye exam	In full after a $5 copayment
Reimbursement for:	
Eyeglass frames	$30
Pair of lenses for the frames	
- Single	$45
- Bifocal	$50
- Trifocal	$55
OR	
Contact lenses	$70

Coverage is provided every 12 months for unmarried, dependent children up to age 19, or up to age 25 if they are full-time students, and every 24 months for adults.

There is no coverage for eye exams performed by non-participating or out-of-state ophthalmologists or optometrists. You may, however, purchase frames, lenses and contact lenses anywhere and apply for reimbursement.

Long-Term Disability

The Long-Term Disability Plan (LTD) is designed to serve the specific interests and needs of the BWPO. The plan will provide a monthly income should you become unable to work because of illness or injury. You are eligible for coverage under this plan immediately upon employment, provided you enroll within 60 days from when first eligible to participate.

Highlights of Coverage

- 60% income replacement after a disability of 90 days. 70% all sources income replacement when LTD is integrated with Primary Social Security Disability Benefits and other sources of disability income (except for an individual policy which need not be considered).
- $30,000 maximum monthly benefit.
- Definition of disability as 'unable to perform duties of one's sub-specialty of medicine'.
- Insures all practice income, rather than base salary. (A bonus unrelated to one's practice of medicine would not be insured.)
- Coverage of partial disability on income loss exceeding 20%.
- No offsets for any disability benefits provided by an individual policy.
- Duration to age 65, if disabled before age 60. Otherwise a maximum duration of 4¾ years to age 70, or one year if disabled after age 70.
- Right to convert current monthly benefit amounts up to $20,000 to an individual contract at termination.
- New employees will be subject to a "3 month/12 month" pre-existing conditions clause. This means if a participant has been treated for a condition within 3 months of first becoming eligible for insurance, the participant will not be insured for this condition until they have participated for at least 12 months. (This condition is waived for new participants who have been covered by a comparable plan for 12 months.)
- Coverage for Infectious/Contagious Diseases, when the medical condition is considered to pose a real or potential risk to others the Professional Staff member may come in contact with in the performance of the duties of his or her occupation.
- If you pay your Long-Term Disability Plan premium through monthly payroll deductions, this benefit will be paid tax-free. Thus, the insurance represents full after-tax replacement income for most participants.

Additional BWPO Policies that Concern Those Receiving LTD Payments:

- Disabled participants in the plan receive continued:
  - Health, dental and vision coverage at the same rate as active employees;
  - Basic group life insurance coverage at no cost;
  - Supplemental group life insurance coverage at the same rate as active employees; and
  - Pension plan contributions

Customized LTD for Academic Medicine

The Long-Term Disability Plan provides special protection related to your profession and includes partial disability benefits.

During this initial enrollment period you have a one time opportunity to enroll in the LTD plan without evidence of insurability.

If you wish to add coverage in the future, you'll need to provide proof of good health.

Life Insurance for Every Need

Depending upon your personal needs, you may insure yourself, your spouse and/or your dependents through the BWPO group life insurance programs.

Up to $1,000,000 of coverage is available on a guaranteed issue basis only during this initial enrollment period. You'll need to provide proof of good health if you wish to add or increase coverage later.

Imputed Income

There is no charge for basic group term life insurance coverage; however, the value of this insurance that exceeds $50,000 will be subject to federal income and Social Security taxes. The value of your life insurance over $50,000 is called "imputed income," and is determined using your age, coverage amount, and the IRS schedule shown on the insert sheet in the back of this guide. Basic term life is reported on your annual W-2 form as taxable income.

Life Insurance

The BWPO sponsors several life insurance plans intended to protect the varied interests and needs of our members. These insurance plans permit a wide range of protections at cost-effective group rates.

Determining Your Needs for Life Insurance Coverage

Everyone has different needs for life insurance. For some, the basic group term life insurance benefit is enough. Others need more insurance to help their survivors. To determine how much life insurance you need, consider the following:

- Does someone other than yourself count on your income?
- How much income would be required to maintain your family at their current living standard over the next 3 to 5 years?
- Do you have a very important future event to protect with insurance, such as children's education or payoff of the mortgage on your home?

If the answer to any of these questions is "yes," consider your options to buy additional coverage.

Highlights of Coverage

Basic Group Term Life Insurance

- You will be covered for life insurance equal to 1 times your annual salary to a maximum of $1,000,000 on a guaranteed issue basis.
- You may limit this insurance to a maximum of $50,000 if desired. Contact the BWPO Human Resources Manager for Professional Staff Benefits or your departmental human resources representative if you would like to do so.

Supplemental Group Term Life Insurance

- You may also purchase additional term life insurance in amounts equal to 1, 2, 3, 4 or 5 times your annual salary up to a maximum of $2,000,000, including Basic Coverage.
- You may enroll for up to $1,000,000 of coverage without evidence of insurability (basic and supplemental combined) only during this initial enrollment period.
- Newly eligible physicians hired after December 31, 2000, can enroll for up to $1,000,000 of coverage with no evidence of insurability required if you enroll within 60 days of date of hire (basic and supplemental coverage combined).
- The insurance premium is based on your age.

Spouse Term Life Insurance

- You may purchase life insurance for your spouse in $25,000 increments up to a maximum of $100,000 not to exceed 50% of the amount of supplemental insurance coverage you have elected for yourself.

Dependent Term Life Insurance

- Coverage of $2,000, $5,000 and $10,000 per child for your children age 6 months to age 15 is available.
- Children 14 days to 6 months are insured for $500.

If both you and your spouse (or same-sex domestic partner) are covered by this insurance policy, you cannot cover each other for spouse life insurance. In addition, you cannot both cover your children under dependent child(ren) life insurance.

Basic Accidental Death and Dismemberment Insurance

- Basic Insurance is provided in an amount equal to 1 times your annual salary, up to a maximum of $500,000.

Supplemental Accidental Death and Dismemberment Insurance

- Supplemental Insurance is available in amounts equal to 1, 2, 3, 4 or 5 times your annual salary, up to a maximum of $2,000,000 including Basic Coverage.

Business Travel Accident Insurance

- If accidental death, dismemberment or total disability occurs while traveling on business, coverage is provided at 3 times your salary, up to $500,000.
- Your employer pays the full cost of this coverage.

Beneficiary Designations

When you are enrolling for life and AD&D insurance, it is important to keep your beneficiary designations current. Your beneficiary is the person(s) who will receive payment of your benefit in the event of your death.

Spending Accounts

The BWPO offers:

- A Health Care Account
- A Dependent Care Account

Highlights of Participation

Spending Accounts let you take advantage of laws that allow you to save on taxes for certain health care and dependent care expenses. There are two separate accounts—one for health care expenses not covered by your medical, dental, or vision plans, and one for dependent care expenses.

- Health Care Account—You may set aside up to $3,000 each year to pay for uninsured medical, dental, and vision expenses with before-tax dollars.
- Dependent Care Account—You may set aside up to $5,000 each year to pay for eligible dependent care expenses with before-tax dollars.

Determining Your Need for a Health Care Account

To determine the level of expenses you are likely to incur, review what you have spent on medical expenses for the last two years. You should also consider how your choice to participate in a particular benefit plan, such as dental or vision coverage, may affect the amount you might contribute.

The examples of eligible expenses shown on the left may help you determine what types of unreimbursed medical expenses you may claim with your Health Care Account. In general, most health care expenses (medical, dental, vision, hearing, etc.) can be paid through your Health Care Account, as long as they are considered eligible medical expenses on your federal income tax return.

The IRS does not recognize a same-sex domestic partner and his/her children as dependents for tax purposes. As a result, their expenses are not eligible for reimbursement through a Health Care Account.

Examples of Eligible Health Care Expenses

In the sidebar you'll find some examples of eligible health care expenses.

Remember! With the range of medical, dental, and vision plans available through the BWPO, some of these expenses may be partially or fully covered, depending upon your personal selections. Any amount covered by your plans is not an eligible expense.

In addition to the specific covered expenses noted here, the program will reimburse you for most other health care expenses that would be deductible under the Internal Revenue Code, except for insurance premium payments and long term care expenses or premiums.

Examples of Eligible Expenses

- **Dental Care—all uninsured dental care including deductibles, coinsurance, and amounts over maximums**
- **Vision Care—exams, and all vision aids not covered by your plan; laser vision correction treatment**
- **Hearing Care—exams not covered by your medical plan, hearing aids and batteries**
- **Prescription Drugs—not covered by your plan, including copayments**
- **Outpatient Psychiatric Care—over benefit maximum**
- **Health Care—deductibles, co-payments, coinsurance, regular checkups and other expenses not covered by your plan (as long as they would qualify for the federal income tax deduction)**

Determining Your Need for a Dependent Care Account

A Dependent Care Account allows you to set aside tax-free dollars to pay for dependent care expenses you incur so that you (and your spouse, if you are married) can work. You may also use a Dependent Care Account if your spouse is attending school full time or is disabled. You may set aside up to $5,000 each year.

The IRS does not recognize a same-sex domestic partner and his/her children as dependents for tax purposes. As a result, their expenses are not eligible for reimbursement through a Dependent Care Account.

Examples of Eligible Expenses

- Nursery schools, kindergartens, day care centers, and summer day camps;
- Dependent care providers in or outside your home;
- Dependent care centers that provide day care (not residential care) for dependent adults; and
- A housekeeper or cook, if services are provided in part to a person who qualifies for dependent care.

Note: A relative who provides dependent care services may be paid for through this account, as long as the relative is not your (or your spouse's) dependent, and is not your child or stepchild who is under age 19 at the end of the year. To be eligible for reimbursement from your Dependent Care Account, your day care provider must submit a Social Security or tax provider identification number.

Expenses for your dependent children are eligible until your child reaches age 13. If you are caring for an elderly family member whom you claim as a dependent for income tax purposes, you may also submit these expenses to your Dependent Care Account.

Deciding How Much to Set Aside in Your Dependent Care Account

Before you decide how much to contribute to your Dependent Care Account, consider:

- Holidays and vacations during which your dependent care needs might change;
- Whether one of your dependents will begin school during the year and need less dependent care; and
- Whether any of your dependents will become ineligible during the year (for example, by reaching age 13).

To qualify for reimbursement, your dependent care expenses cannot exceed the earned income of the lesser-earning spouse.

Save on Taxes

When you participate in a Dependent Care Account, you save at least 20% on your eligible expenses.

Internal Revenue Service Rules: Use It or Lose It

Be sure to estimate your health care and dependent care expenses carefully. Under IRS rules, you must forfeit any unused account balance(s) remaining at year end. Generally, you cannot change or stop contributing during the year unless you have a qualified change of status. You have until March 31st of the subsequent year to submit for reimbursement any expenses you incurred before the end of the previous calendar year.

For a complete list of eligible expenses, go to the IRS website (http://www.irs.ustreas.gov/prod/forms_pubs/pubs.html) and print off the publications.

Professional Staff Retirement Plan

Eligibility

Professional Staff members who hold a Harvard Medical School teaching faculty appointment will be eligible to join the Plan after completing one year of service (1,000 paid hours in 12 consecutive months). Service includes foundation and BWH service before January 1, 2001.

Amount of Contributions

The Professional Staff Plan is a Section 403(b) defined contribution plan. For participants working 1,000 hours or more each year, the BWPO and/or BWH make all contributions to the plan.

Contributions on BWH Salary Sources

BWH makes contributions to the plan based on your age and salary*:

- If you are under age 40 on June 30, BWH will contribute an amount equal to 5% of your BWH salary up to the Social Security wage base**, and 10% of your BWH salary above the Social Security wage base.
- If you are age 40 or over on June 30, BWH will contribute an amount equal to 11% of your BWH salary up to the Social Security wage base, and 16% of your BWH salary above the Social Security wage base.

* Up to $170,000 for 2001, as well as any further limits imposed by the IRS.

** The Social Security wage base is $80,400 for 2001, and is adjusted annually.

Contributions on BWPO Salary Sources

Please refer to the pension insert in your enrollment packet for details regarding BWPO contributions under the plan.

Your total contributions (based on BWH and BWPO pay) are subject to integration with regard to IRS limits as well as the Social Security wage base, if applicable.

Cost

There is no cost or contribution required on your part. The BWPO/BWH pays the full cost of providing benefits under the plan.

Vesting

Vesting refers to your right to, or ownership of, contributions made by the BWPO/BWH to your personal account(s) under the plan and investment returns on those contributions.

Vesting on BWH Contributions

You will be 100% vested in your BWH account(s) after you have met the eligibility requirements (generally after completing one year of service).

Vesting on BWPO Contributions

Please refer to the pension insert in your enrollment packet for vesting service requirements applicable to your BWPO contributions.

Investment Options

You may invest your contributions in any one, or a combination of, the following three options:

- TIAA-CREF (Teacher's Insurance and Annuity Association – College Retirement Equities Fund)
- Fidelity
- Vanguard

Among these vendors, you will find a wide range of investment choices, including fixed and variable annuities, and hundreds of mutual funds, allowing you to build a diversified portfolio that fits your personal goals and risk tolerance.

Your contributions may be directed to up to two vendors simultaneously, and you may redirect your contributions at any time.

Termination of Employment

If you leave before retirement and after becoming vested, you have the option of taking all or a portion of your account balance with you or leaving it to accumulate investment returns until you choose to retire.

Payment Options

If you are vested when you leave, you have the option of receiving a lump sum or leaving it in the plan to accumulate investment returns until you are ready to begin receiving payments.

When you are ready to receive benefits, there are several forms of payment to consider, including cash, annuity payments, systematic withdrawals, and minimum distributions.

Survivor Benefits

If you are vested and die before reaching retirement age, your surviving beneficiary will receive the full balance in your account. If your death occurs after you have begun receiving payments, the payment option you selected prior to retirement will determine whether and how payments continue to your spouse or beneficiary.

Tax Sheltered Annuity Program (TSA)

- You may set aside a portion of your pay to purchase a tax-sheltered annuity (TSA) to supplement your retirement income.
- A TSA offers you the opportunity to reduce current income taxes, defer taxes on your investment earnings and save for your retirement.
- Since your eligibility to make tax-deductible contributions to an Individual Retirement Account (IRA) is affected by pension plan membership and income levels, participation in the TSA can be an excellent alternative.
- You may enroll in the TSA Program at any time.
- The maximum allowable contribution may be as much as 25% of your annual salary, up to a limit of $10,500 per year.
- At the time you enroll, you will need to decide how to invest your savings. The BWPO Human Resources Manager for Professional Staff Benefits or your departmental human resources representative can provide you with information on the investment options available.
- Early access to money contributed to a TSA program is limited, and penalties apply to any funds withdrawn prior to age 59½.

Before you enroll in a TSA, please contact the BWPO Human Resources Manager for Professional Staff Benefits or your departmental human resources representative for a complete description of the program.

Additional Benefits

The BWPO is part of a large community and extends to its employees a vast array of conveniences and services that make working here a pleasure. Just a few are listed here:

- **Longwood Medical Area Child Care Center (LMACCC)**—LMACCC reserves more than 50 spaces for the BWH and BWPO on a first come first served basis.
- **Parents-In-A-Pinch**—Parents-In-A-Pinch provides back-up child care at a subsidized rate. These family care programs also include access to services offered by Harvard Medical Center Office of Work & Family.
- **Parking**—The transfer to the BWPO should have no effect on your current parking arrangements.
- **Medical Area Federal Credit Union (MAFCU)**—This provides you with a wide range of highly competitive financial products and services.
- **Direct Deposit** — Enjoy the convenience of having your paycheck automatically deposited into your bank account.

YOUR COBRA RIGHTS

When you or your covered dependents are no longer eligible for coverage under your BWPO medical, dental, vision care plan or health care spending account, you or your covered dependents may be eligible to continue this coverage as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA).

To continue your coverage (or your dependents' coverage), you will pay up to 102% of the premium cost. This law applies to you if you lose eligibility for coverage due to:

- Termination of employment (for reasons other than gross misconduct);
- Reduction of work hours;
- Divorce or legal separation;
- Your death;
- Your entitlement to Medicare benefits; or
- Loss of status as an eligible dependent.

Contact the Human Resources Manager for Professional Staff Benefits or your departmental human resources representative if you have any questions about COBRA.

The period of COBRA coverage begins with the date of your qualifying event and continues for up to 18 months from that qualifying event in most cases. If you continue your coverage under COBRA due to divorce or loss of status as an eligible dependent, however, COBRA coverage is available for 36 months. If you are qualified for disability under Title II or Title XVI of the Social Security Act after you accept COBRA coverage, your COBRA coverage continues for up to 29 months. You will pay up to 150% of the premium cost during the 19th through 29th months.

HOW TO ENROLL FOR COBRA CONTINUATION COVERAGE

To enroll for continuation coverage under COBRA complete a COBRA election form which will be mailed to you upon termination from BWPO or upon reduction in work hours, or which is available from the BWPO Human Resources Manager for Professional Staff Benefits or your departmental human resources representative. Divorced spouses or individuals who lose status as eligible dependents should call the BWPO Human Resources Manager for Professional Staff Benefits or your departmental human resources representative. Return your completed election form to the address on the form within 60 days from your date of termination of coverage or your notification of COBRA eligibility, whichever is later. If you do not return your completed form, the BWPO will assume that you are waiving continued coverage under COBRA, and you will not be allowed to continue your coverage in the plan. (**The 60 days will** be counted from the date of the COBRA eligibility notice to the postmarked date of your mailed election form.)

WHEN YOUR COBRA COVERAGE ENDS

Your COBRA coverage will end when:

- You reach the maximum length of time allowed for your COBRA coverage (for example, 18 months or 29 months or 36 months from your qualifying event). (If you are continuing your coverage beyond 18 months due to disability, your coverage will end when you are no longer disabled or after 29 months, whichever is sooner.);
- You fail to make timely payment of your COBRA premiums;
- You enroll in another employer-sponsored health care plan and that plan does not include pre-existing conditions limitations or waiting periods; or
- You become entitled to Medicare benefits.

In addition, your COBRA coverage described in this chart will end when the BWPO terminates its agreement with the health care companies which administer the plans. In this case, your COBRA coverage may continue under another health care plan.

HIPAA PROVISION

If You Declined Medical Coverage Because You Have Coverage Elsewhere

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you may have the opportunity to enroll yourself and your eligible dependents for medical coverage during the year if you previously declined coverage as follows:

- You and/or your dependents have coverage from another source (such as your spouse's medical plan or COBRA coverage) and you lose that coverage; or
- You acquire a dependent through marriage, birth, adoption or placement for adoption.

If you need to enroll for coverage as a result of one of the above events, you must do so within 31 days of the event. Otherwise, you may be required to wait until the next open enrollment period.

Brigham and Women's Physicians Organization
Monthly Rates Effective 1/1/01

Medical Insurance

Employee contributions for Medical, Dental and Vision Insurance are as indicated below. Your cost will depend on which plan you select.

	Individual	Family
BC/BS Partners Plus	$ 23.62	$ 59.02
BC/BS Partners Value	$ 0.00	$ 0.00
BC/BS Master Health	$131.52	$328.81
Harvard Pilgrim HealthCare	$ 44.85	$112.15
Neighborhood Health Plan	$ 35.92	$ 89.83
Tufts Health Plan	$ 46.11	$115.27
Opt-out (Proof of alternate coverage is required)	$75.83 added to pay	

Dental Insurance

	Individual	Family
BC/BS Dental	$ 5.24	$ 13.09

Vision Insurance

	Individual	Family
BC/BS Vision Care Plan	$ 1.56	$ 3.90

Long Term Disability Insurance

The premium for this insurance is 0.90% of salary.
(Coverage equals 60% of BWH and BWPO salary).

Basic Group Term Life Insurance Plan

The BWPO and/or BWH pay the premium for this insurance, however, the value of your Basic Group Term Life Insurance coverage that exceeds $50,000 will be subject to federal income and Social Security taxes. Called "imputed income", it is determined using your age, coverage amount, and the IRS schedule shown here. Imputed income resulting from your Basic Group Term Life Insurance is shown on your pay stub under the heading "Excess Life".

Your age as of December 31	Annual rate per $1,000 of Coverage
Under 25	$ 0.60
25-29	0.72
30-34	0.96
35-39	1.08
40-44	1.20
45-49	1.80
50-54	2.76
55-59	5.16
60-65	7.92
65-69	15.24
Age 70 and over	24.72

Table rates effective 7/1/99

The Tax Advantage*

Any payroll deductions you authorize as payments for medical, dental, vision, and health care or dependent care accounts are made on a pre-tax basis. The tax savings occur because you do not pay federal or state income taxes, or Social Security taxes on the pre-tax dollars you use to pay for these benefits.

*Due to IRS regulations, does not apply if participation is through the Same-Sex Domestic Partners Coverage Program

EX. 7

BRIGHAM AND WOMEN'S HOSPITAL
MEDICAL STAFF

FAMILY AND MEDICAL LEAVE POLICY

A. **Applies To:** All physicians, dentists, podiatrists, psychologists and Ph.D. researchers who are members of the Brigham and Women's Hospital ("BWH") medical staff and are employed by BWH or the Brigham and Women's Physicians Organization ("BWPO"), excluding residents and fellows. Individuals covered by this policy are hereafter referred to as "Employees". BWH and BWPO are hereafter referred to as the "Employer".

B. **Eligibility**

Any Employee who has been employed by the Employer for at least twelve (12) months and has worked at least 1250 hours during the past twelve (12) months is eligible for a maximum of twelve (12) weeks of family and medical leave[1] for one or more of the following reasons:

(1) Because of the birth or placement for adoption[2] or foster care of a new son or daughter and in order to care for that child;

(2) To care for a parent, spouse, son or daughter with a serious health condition; and

(3) Where a serious health condition makes the Employee incapable of performing his or her job.[3]

Except as otherwise provided in this policy, an Employee may take no more than twelve (12) weeks of family and medical leave during any one year period. For purposes of this policy, each one year period is measured backward from the date an Employee uses any family and medical leave.

C. **Paid or Unpaid Leave**

(1) Family and medical leave taken pursuant to this policy is unpaid except as provided in paragraphs 2-4 below.

(2) A female Employee taking leave for the purposes of giving birth will be considered as disabled for a period of eight (8) weeks and will receive paid leave for such period.[4]

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[1] This policy is intended to comply with the Family and Medical Leave Act of 1993 and will be implemented accordingly.
[2] A female Employee who does not meet the above eligibility requirements may still be eligible for maternity or adoption leave pursuant to the Massachusetts Maternity Leave Act (See Section K).
[3] If an Employee has questions as to whether an illness, injury or impairment constitutes a "serious health condition" for purposes of this policy, he/she should contact the appropriate Department administrator.
[4] The Employee will be paid her base salary during this eight (8) week period.

(3) An Employee taking adoption leave will be eligible for eight (8) weeks of paid leave.[5] Provided, however, in the event that both adoptive parents are employed by either BWPO and/or BWH, only one parent will be entitled to paid leave.[6]

(4) For any leave or portion of leave under this policy which is unpaid, an Employee may elect or the Employer may require, the Employee to use any accrued vacation or personal leave (and any accrued sick leave if the Employee's own serious health condition is the reason for the leave).[7]

D. Notice to Employer

In order to take family and medical leave under this policy, an Employee must notify the designated Department Administrator at least thirty (30) days prior to commencing leave. A form for requesting leave is available from the Department Administrator. This notice requirement may be waived if the Employer determines that an Employee's failure to give notice was the result of an emergency or other unforeseeable circumstances. When the need for leave is not foreseeable thirty (30) days in advance, an Employee must give notice to the Employer within two (2) working days of learning of the need for leave, absent extraordinary circumstances. If the Employee knew about the need for leave, but failed to give timely notice, the Employer may deny the taking of leave until thirty (30) days after the date of the Employee's request.

E. Conditions on the Use of Leave

(1) Leave taken for purposes of birth and caring for a new son and daughter, or placement of a new son or daughter for adoption or foster care must be taken consecutively during a period of no more than twelve (12) weeks and must be concluded within one (1) year of the birth or placement for adoption or foster care. Such leave may not be taken on an intermittent (two or more separated leave periods) basis. With the agreement of the Employer, birth, adoption or foster care leave may be taken on a reduced work schedule (where an Employee continues to work, but for fewer hours per day or for fewer days per week). Provided, however, a reduced work schedule leave for birth, adoption or foster care must nonetheless be taken during a period of no more than twelve (12) consecutive weeks and must be concluded within one (1) year of the birth or placement for adoption.

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[5] The Employee will be paid his/her base salary during this eight (8) week period.

[6] For example, if one adoptive parent is employed by BWH and the other adoptive parent is employed by BWPO, the parents must elect which parent will receive paid leave. The other parent may be entitled to unpaid leave as provided elsewhere in this policy.

[7] The amount of vacation, personal leave, and sick leave, if any, which an Employee accrues, and the requirements for use of any such vacation or leave are governed by the policies of the Employee's Department or Division. The use of vacation, personal leave or sick leave will not increase the total length of the leave. For example, if a female Employee takes leave for the birth of a child, she will be entitled to eight weeks of paid leave pursuant to section C. (2) of this policy. If that Employee has four weeks of accrued vacation time, she may elect or the Employer may require (depending on Departmental or Division policies) to use her accrued vacation pay for weeks nine (9) through twelve (12) of the leave. However, regardless of whether or not the employee receives accrued vacation pay for weeks nine (9) through twelve (12), the maximum length of her leave is twelve (12) weeks.

(2) Intermittent or reduced leave may be taken when medically necessary, as a result of an Employee's serious health condition or that of a parent, spouse, son or daughter. In such cases, the total number of hours or days of leave taken by the Employee is limited to the equivalent of twelve (12) workweeks for that employee. If an Employee desires to take intermittent or reduced schedule leave, the Employee must provide the Employer with medical certification that it is medically necessary for the Employee to be absent from work on an intermittent or reduced basis, and the expected duration and schedule of intermittent or reduced leave. Employees needing intermittent or reduced leave must attempt to schedule their leave so as not to unduly disrupt the Employee's operations. The Employer may transfer the Employee during the period of intermittent or reduced schedule leave to an available alternative position with equivalent pay and benefits for which the Employee is qualified if that position can accommodate recurring periods of leave better than the Employee's regular position.

(3) If both husband and wife are employed by the same Employer, they are together entitled to a maximum of twelve workweeks of leave for the birth, adoption or foster care placement of a child or to care for a parent with a serious health condition.

F. Benefits

An Employee on a leave pursuant to this policy may remain a participant in the Employer's insurance benefit plans throughout the duration of the leave.[8] During the leave, the Employer will continue to pay its share, if any, of the premiums. In the event that the Employee does not return to work after his/her leave, the Employer may require the Employee to reimburse the Employer for the full cost of health insurance premiums paid by the Employer while the Employee was on leave. The Employer will also continue to make pension contributions (subject to all eligibility requirements) during any period of paid leave under this policy.

G. Medical Certification

An Employee requesting leave because of a serious health condition of the Employee or the Employee's parent, spouse or child must furnish the Employer with appropriate medical certification. The certification must be signed by the appropriate health care provider on the form which may be obtained from the designated Department representative. The Employee must provide the certification as soon as practicable (generally at the same time as the request for leave), but no later than fifteen (15) calendar days after the Employee requests leave. The Company may also require a second opinion from a health care provider of its own choosing, and if necessary, a third opinion from a health care provider jointly chosen by the Employer and the Employee regarding the serious medical condition upon which leave is to be or has been taken under this policy. If the Employer requires that an Employee obtain a second or third opinion, the Employer will pay the costs associated with obtaining that opinion.

When an Employee is on leave, subsequent recertifications may be required periodically or in other appropriate circumstances such as when the

[8] Departmental policies govern accrual of vacation, sick leave or personal leave during periods of leave.

Employee seeks to extend the leave or there is a change in the serious health condition for which the leave is taken. The Employer may also require periodic updates of the Employee's health status and intent to return to work.

H. Return to Work

An Employee who takes leave under this policy will be restored to his/her same position or to an equivalent position upon return from leave provided that the Employee's job still exists and the Employee would have continued to be employed in that job had he or she not taken leave.[9]

An Employee who takes leave as a result of his/her own serious health condition will be required to provide a fitness for duty certification signed by a health care provider before returning to work. An Employee may not return to work until he/she provides such a certification.

I. Extension of Leave

Requests for extension of leave beyond the twelve (12) weeks provided for in this policy will be considered on a case-by-case basis by the Employee's Department Chairman.

J. Termination

An Employee who does not return from his/her leave, and is not granted additional time off will be terminated effective as of the earlier of the date the Employer learned that the Employee does not intend to return to work or the last day of the leave.

K. Maternity/Adoption Leave Under Massachusetts Law for Female Employees Who Are Ineligible for Leave Under the Family and Medical Leave Act

A female Employee who is ineligible for leave under the Family and Medical Leave Act, but who has completed at least three (3) months of employment will be entitled to twelve (12) weeks [10] of maternity leave for the purposes of giving birth or adopting a child under eighteen (18) years of age or under twenty-three (23) years of age if the child is mentally or physically disabled. In order to be eligible for FMLA leave, an Employee must have been employed by the Employer for at least twelve (12) months and have worked a minimum of 1250 hours during the past twelve (12) months. A female Employee who does not meet these requirements may nonetheless be eligible for maternity or adoption leave under the Massachusetts Maternity Leave Act (MMLA) as further described in this section, provided she has completed at least three (3) months of employment. Likewise, a female Employee who has already exhausted her FMLA leave benefits during the previous twelve (12) months for other qualifying reasons may be

[9] The Employer may deny reinstatement to an Employee if the Employer determines that the individual is a key employee whose reinstatement would cause substantial and grievous economic harm to its operations. The Employer will inform any Employee who is within this category of his/her status as a key employee before commencement of leave.

[10] Massachusetts law requires that eight (8) weeks of leave be provided under these circumstances. The Employer has decided to expand the benefit to twelve (12) weeks.

eligible for leave under the MMLA. In order to be eligible for such a leave, the Employee must give the designated Department representative at least two (2) weeks notice of her anticipated date of departure and intention to return to work. Salary and benefit continuation during said leave shall be as described in sections C and F above. Provided, however, no Employee shall be entitled to more than a total of eight (8) weeks paid leave under this policy in any twelve (12) month period.

At the conclusion of this maternity leave, the Employee will be reinstated to her previous or similar position with the same salary that she received at the commencement of the leave. The Employer, however, reserves the right not to reinstate the Employee to her previous or similar position if other Employees of equal seniority and status in the same or similar positions have been laid off due to economic conditions or have been otherwise affected by changes in employment conditions during the period of maternity leave.

L. Effect of Leave Upon Periodic Duties

Annual administrative, on-call, teaching and academic duties shall be reduced in proportion to the number of weeks that an Employee is on leave under this policy. Specific implementation of this provision shall be determined by individual Department policies.

Approved: BWH Chiefs 10/15/01
BWPO Executive Committee 11/05/01

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